

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 See birth cert.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01943

CERTIFICATE OF DEATH

01937

1. DECEASED-NAME (Type or print) Baby Girl <b>Abbott</b>			2a. DATE OF DEATH 2 Month 1 Day 69 Year			2b. HOUR 7:45 A M							
3. SEX F		4. RACE W		5. DATE OF BIRTH 2/1/69			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.							
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.			13b. COUNTY -		13c. CITY OR TOWN Glen Rock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RFD#3 Dear Meadows Farm				
14. FATHER'S NAME First Middle Last DAVID D. ABBOTT			15. MOTHER'S MAIDEN NAME First Middle Last SYLVIA JANE JOHNSON			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Address MOTHERS CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FAILURE OF RESPIRATION AND CARDIAC FUNCTION</u> 7692 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>MATERNAL HYDROAMNIOS &amp; PREMATURE LABOR</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>69</u> , to <u>2/1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Dernon C. Kelly MD</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2/1/69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
23a. BURIAL (CREMATION REMOVAL) <u>REMOVAL</u>			23b. DATE 2/4/69		23c. NAME OF CEMETERY OR CREMATORY GBMC			23d. LOCATION (City or Town) (County) (State) Towson Balt, Md					
24. FUNERAL DIRECTOR <u>R. Breitenicker</u>						ADDRESS GBMC			25a. REC'D BY REGISTRAR DATE FEB 7 1969		25b. REGISTRAR'S SIGNATURE <u>J. Chomley</u>		

01337

01337

X

DAVID C. ABBOTT SYLVIA JANE ABBOTT

MOTHERS CHART

NO

112

X

01337 01337 01337

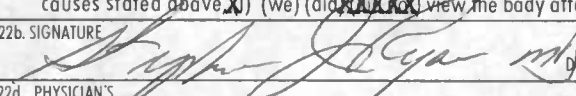
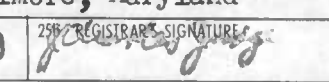
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

01944

01938

1. DECEASED-NAME (Type or print) <b>PEARL</b>			First Middle Last <b>GARRIOTT ABBOTT</b>			2a. DATE OF DEATH Month Day Year <b>FEBRUARY 16, 1969</b>			2b. HOUR <b>4:50 AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>NOVEMBER 19, 1878</b>			6. AGE (In years last birthday) <b>90 82</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOSPITAL VETERANS ADMINISTRATION</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CARPENTER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>3042 PINWOOD AVENUE</b>			14. FATHER'S NAME First Middle Last <b>ROBERT ABBOTT</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY GARRETT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>SPANISH AMERICAN 218 07 6297</b>			17. INFORMANT <b>CLINICAL RECORDS, VA HOSP, FT HOWARD, MD</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE. CONGESTIVE</b> DUE TO, OR AS A CONSEQUENCE OF <b>HEART FAILURE</b> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ((a))											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/5/69</b> , 19__, to <b>2/15/69</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/15/69</b> , 19__, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did not) view the body after death.											
22b. SIGNATURE 			22c. DATE SIGNED <b>2 17 69</b>			22d. PHYSICIAN'S NAME (Type) <b>STEPHEN J RYAN, M.D.</b>			22e. ADDRESS <b>VA HOSPITAL, FT HOWARD, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>2/19/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, National</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>RUCK FUNERAL HOME, HARFORD RD, BALTO, MD</b>						25a. REC'D BY REGISTRAR <b>FEB 17 1969</b>			25b. REGISTRAR'S SIGNATURE 		

01232

RECEIVED

01232

TO: DIRECTOR, FBI (100-374301) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR TRIP TO AFRICA; NEW YORK, NEW YORK, 10/10/68.

RE NEW YORK TELETYPE TO BUREAU, 10/10/68, AND BUREAU TELETYPE TO NEW YORK, 10/10/68.

ON 10/10/68, NEW YORK ADVISED THAT JAMES EARL RAY, AKA, HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.

NEW YORK ADVISED THAT RAY HAD REFUSED THE OFFER AND HAD BEEN ADVISED THAT THE INDIVIDUAL HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.

NEW YORK ADVISED THAT RAY HAD REFUSED THE OFFER AND HAD BEEN ADVISED THAT THE INDIVIDUAL HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.

NEW YORK ADVISED THAT RAY HAD REFUSED THE OFFER AND HAD BEEN ADVISED THAT THE INDIVIDUAL HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.

NEW YORK ADVISED THAT RAY HAD REFUSED THE OFFER AND HAD BEEN ADVISED THAT THE INDIVIDUAL HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.

NEW YORK ADVISED THAT RAY HAD REFUSED THE OFFER AND HAD BEEN ADVISED THAT THE INDIVIDUAL HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.

NEW YORK ADVISED THAT RAY HAD REFUSED THE OFFER AND HAD BEEN ADVISED THAT THE INDIVIDUAL HAD BEEN ADVISED BY AN INDIVIDUAL WHO OFFERED HIM \$10,000 TO ASSIST HIM IN OBTAINING A PASSPORT FOR A TRIP TO AFRICA.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-69

<div style="display: flex; justify-content: space-between;"> <span>01945</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>01939</span> </div>											
1. DECEASED-NAME (Type or print) <b>Charles John Adams</b>				2a. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1969</b>				2b. HOUR a. M. <b>7:50</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-26-1884</b>				6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b>84</b> DAYS <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired, Bethlehem Steel Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>#21222 6907 Dunmanway Apt. E3</b>		
14. FATHER'S NAME First <b>John</b> Middle <b>Adams</b> Last <b>Adams</b>				15. MOTHER'S MAIDEN NAME First <b>Susie</b> Middle <b>Horwarth</b> Last <b>Horwarth</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war and date of service)				16b. SOCIAL SECURITY NO. <b>213-07-6515-A</b>		17. INFORMANT Address <b>7909 Trappe Rd. Dundalk, Md. 21222</b> <b>Daughter: Mrs. Martha White</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with hemorrhage.</b> <b>1538</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <b>January 5, 1969</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abscess of abdominal cavity.</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>19</b> Day <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b>7620 York Road</b>		City or Town <b>Towson</b>		County <b>Baltimore</b>		State <b>Md.</b>	
22a. I certify that <b>IX</b> (this hospital) attended the deceased from <b>December 24 1968</b> , to <b>February 5 1969</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>February 5, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Eugenio Antonio</i>						DEGREE <b>ATTENDING PHYS.</b> <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>February 5, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>Eugenio Antonio, M.D.</b>						22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Feb-7-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md. 21213</b>			
24. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, Dundalk, Maryland 21222</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 10 1969</b>		25b. REGISTRAR'S SIGNATURE <i>W. L. ...</i>			

RECEIVED

NO

OCT

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A			
Earl Thomas Alt						February 8 1969			7:35 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		10-27-14			34 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Baltimore		U.S.A.				Baltimore Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			St. Joseph Hospital			unemployed						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Balto.		21234				8552 Willow Oak Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
George Alt			Grace Boyed									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
No			215 05 2458			Wife- Lillian - same address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from <u>2-8</u> , 19 <u>69</u> , to <u>2-8</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>2-8-69</u> 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Christine Feliciano, M.D.</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2-8-69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Christine Feliciano, M.D.</u>						22e. ADDRESS <u>7620 York Road, Towson, Md. 21204</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial		2/11/69		Moreland Memorial Park		Baltimore Co., Maryland						
24. FUNERAL DIRECTOR ADDRESS						25a. FEB 11 1969		25b. REGISTRAR'S SIGNATURE				
Wm. E. Johnson 8521 Loch Raven Blvd. 21204						DATE						

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

10010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>JULIUS</b>			First <b>ALTER</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1969</b>			2b. HOUR <b>12:50</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 1, 1885</b>			6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Towson Conv. Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Phila. Rd. &amp; Middle River Rd</b>
14. FATHER'S NAME First <b>Dominick</b> Middle <b>Alter</b> Last <b>Alter</b>			15. MOTHER'S MAIDEN NAME First <b>Magdalena</b> Middle <b>Himmelsbach</b> Last <b>Himmelsbach</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>212-01-3211</b>		17. INFORMANT <b>Frederic W. Alter</b> Address <b>Abingdon, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>67</b> , to <b>2/17</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/17/69</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Laurence C. Post M.D.</b>			22c. DATE SIGNED <b>2/17/69</b>						
22d. PHYSICIAN'S NAME (Type) <b>Laurence C. Post</b>			22e. ADDRESS <b>6805 York Rd. Baltimore, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Feb. 20, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Francis de Sales</b>		23d. LOCATION (City or Town) (County) (State) <b>Abingdon Harford Md.</b>		
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son</b>			ADDRESS <b>Abingdon, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <i>Mollie E Anagnost</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>1</i> Year <i>69</i>			2b. HOUR <i>1:45</i> M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Sept 23, 1882</i>		6. AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.				
10. CITY OR TOWN OF DEATH <i>CATONSVILLE MD</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>WOODLAWN</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1906 ALTO VISTA Ave</i>	
14. FATHER'S NAME First <i>GEORGE U.</i> Middle <i>DIETZ</i> Last <i></i>				15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>MEHL</i> Last <i>GARTEN</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service) <i>---</i>			16b. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>CHART</i> Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rt Pulmonary embolus</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Cardiovascular disease with stroke of the left side</i> DUE TO, OR AS A CONSEQUENCE OF <i>Fracture of Right hip at Greater Sciatic Foramen</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/17</i> , 19 <i>69</i> , to <i>2/1</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/31</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John and Kenneth</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/1/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>E. KASAITIS, M.D.</i>			22e. ADDRESS <i>1801 Frederick Road Balto 42122</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Feb. 4, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>		23d. LOCATION (City or Town) (County) (State) <i>Woodlawn Balto. Md.</i>				
24. FUNERAL DIRECTOR <i>John T. Stansbury, Sr. - 6411 Windsor Mill Rd. 21207</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>FEB 4 1969</i>										

042870

RECEIVED

042870



039: 6 031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Esther APPLESTINE</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>FEB 11 1969</b>		2b. HOUR <b>5:45 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>10/28/1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		Md.		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto County Gen Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER APT. 203 <b>8607 Gray Fox Rd</b>	
14. FATHER'S NAME First Middle Last <b>ALTER HYMAN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or (unknown) (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MR. SIMON APPLESTINE</b> <b>8607 GRAY FOX RD., RANDALLSTOWN</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIO SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 25</b> , 1969, to <b>FEB 11</b> , 1969, that (I) (we) last saw the deceased alive on <b>FEB 11</b> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Fausto Q. Aquino Jr</b> DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>2-11-69</b>				
22d. PHYSICIAN'S NAME (Type) <b>FAUSTO Q. AQUINO JR</b>						22e. ADDRESS <b>BALTO. COUNTY GEN. HOSP.</b>				
23a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>		23b. DATE <b>2-12-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>				
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b> ADDRESS						25a. REC'D BY REGISTRAR DATE <b>FEB 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>		

311004

10/28/2018 8:01

2001

1990

For the County of San Diego

Handwritten: 1/2nd 11/25/01

448

42

1. 2017-2018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

01950

01945

1. DECEASED-NAME (Type or print) First Middle Last MILDRED N. ARNOLD			2a. DATE OF DEATH Month Day Year FEBRUARY 9, 1969			2b. HOUR 8:30 A.M.						
3. SEX female		4. RACE white		5. DATE OF BIRTH June 16, 1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2030 Old Frederick Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2030 Old Frederick Rd.			
14. FATHER'S NAME First Middle Last Edwin L. Nusz				15. MOTHER'S MAIDEN NAME First Middle Last Nettie V. Keefer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) none		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs Dorothy A. Callahan 2030 Old Fred.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left breast 174X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1-8-1969, to 1-9-1969, and that in (my) (our) opinion death occurred on the date and hour and from the saw the deceased alive on 1-9-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. Barba Colin						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-10-69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb 12, 1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland				
24. FUNERAL DIRECTOR Sterling Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21226						25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE				

41842

CERTIFICATE OF DEATH

41850

418

Coroner of City and County of San Francisco

10-10-1910

10-10-1910

John A. Cohn



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

01951

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01946

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 330 PM	
Katherine		Baranyai			February 21, 1969			
3. SEX F	4. RACE W	5. DATE OF BIRTH Nov. 7, 1882			6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Hungary	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Halethorpe	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1941 Belle Avenue 21227				
14. FATHER'S NAME First Middle Last Henry Marks		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth (Unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Gertrude E. Clazey, 1941 Belle Avenue 21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> <u>4349</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>10 a</u> , 19 <u>62</u> , to <u>21 Feb</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>20 Feb</u> 19 <u>62</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>William Goodman</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>21 Feb 69.</u>		
22d. PHYSICIAN'S NAME (Type) William Goodman, M.D.		22e. ADDRESS 1334 Sulphur Spring Road						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 24, 1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Balto. City, Baltimore Md.		
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE FEB 25 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Image</u>		

VR 113  
45M - 113

11222

11222

THE NATIONAL ARCHIVES, COLLEGE PARK, MARYLAND 20740

RECORDS OF THE

To: Mr. J. Edgar Hoover

Director

FBI

Re:

Mr. J. Edgar Hoover

T

Enclosed

U. S. A.

1

1. A copy of the letterhead memorandum dated 10/1/50

10/1/50

2. A copy of the letterhead memorandum dated 10/1/50

10/1/50

(Enclosed)

10/1/50

3. A copy of the letterhead memorandum dated 10/1/50

10/1/50

*Handwritten signature*

Very truly yours,

*Handwritten signature*

*Handwritten signature*

Very truly yours,

Walter G. Clegg

Very truly yours,

John Edgar Hoover

10/1/50

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
01952						01947									
1. DECEASED-NAME (Type or print)						First Middle Last			2a. DATE OF DEATH			2b. HOUR			
DAISY LEE BARRETT									February 16, 1969			M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female			White			September 6, 1902			66 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
N. Carolina			U.S.A.						Baltimore						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore			1005 Leeds Avenue			Housewife									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
Maryland			Baltimore			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			1005 Leeds Avenue 21229			
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last									
William F. Smith						Ada Wade									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
No									Mr. William J. Barrett, 1005 Leeds Avenue						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>A.S.C.U.D. with coronary insufficiency</u>															
4124 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>Carcinoma of the sigmoid colon</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>Metastasis to liver</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Robert B. McFadden</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type) Dr. Robert B. McFadden						22e. ADDRESS 3350 Wilkens Avenue, Balto., Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
BURIAL			2-19-1969			Loudon Park Cemetery			Baltimore, Maryland						
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Howard H. Hubbard, 4107 Wilkens Ave. 21229						FEB 19 1969		<u>Howard H. Hubbard</u>							

1917

RECEIVED

1918

TO THE HONORABLE SECRETARY OF THE ARMY

WASHINGTON, D. C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 14th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours truly,  
J. H. ...

Very truly yours,  
J. H. ...

Enclosed for you are two copies of the report of the ...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01953		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01948	
Item 23 Film G409 2/17/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last WALTER Frederick BAUMGART		2a. DATE OF DEATH FEB Month 4 Day 69 Year	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 3/31/21	
7b. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		6. AGE (In years lost birthday) 47 YRS.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Cent		9. COUNTY OF DEATH BALTIMORE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto. Bowleys Qts.		13c. STREET AND NUMBER Box 323, Rt. 15	
14. FATHER'S NAME First Middle Last Emil Baumgart		15. MOTHER'S MAIDEN NAME First Middle Last Katherine Durr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes WW 2-Army		16b. SOCIAL SECURITY NO. 217-26-2113		17. INFORMANT Nellie (nee Marsh) wife, above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b> <b>150X</b> DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF ESOPHAGUS WITH METASITISIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 23</b> , 19 <b>68</b> , to <b>FEB 4</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>FEB 4</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (do) (did not) view the body after death.					
22b. SIGNATURE <i>Eduardo N. Canilang</i> DEGREE				22c. DATE SIGNED <b>2/4/69</b>	
22d. PHYSICIAN'S NAME (Type) DR. EDUARDO CANILANG				22e. ADDRESS 6701 N. CHARLES ST. TOWSON, MD 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE <b>2/27/69</b>		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens	
				23d. LOCATION (City or Town) (County) (State) Bel Air, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REC'D BY REGISTRAR FEB 10 1969	
				25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>	

01528

UNITED STATES

RECEIVED

12

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/1/69

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First HILDA		Middle RUTH		Last BELL		2a. DATE OF DEATH FEB Month 13 Day 69 <sup>eor</sup>		2b. HOUR A 10:30			
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH Oct 4 1907			6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Marland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto Med Cen			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) At Home			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Parkville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3231 E. Joppa Rd.			
14. FATHER'S NAME First Middle Last Joseph Sindall					15. MOTHER'S MAIDEN NAME First Middle Last Kate Jay									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.			16b. SOCIAL SECURITY NO. 220-20-7270			17. INFORMANT Hospital records			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 174X DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA RIGHT BREAST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from FEB 10 19 69, to FEB 13 19 69, that (I) (we) last saw the deceased alive on FEB 13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE R. Vasudeva								DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-13-69		
22d. PHYSICIAN'S NAME (Type) R. VASUDEVA								22e. ADDRESS 6701N. CHARLES ST. BALTO. MD 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/17/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk,			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland						
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road						25a. REC'D BY REGISTRAR DATE FEB 17 1969		25b. REGISTRAR'S SIGNATURE						

MEDICAL CERTIFICATION

01222

01222

0400 12 1970 1970 1970 1970

001 # 1207

STATE

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

PAID

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01955

01950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
Joseph		Benyo, Sr.						Feb.		23		1969				1:30 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Mald		White		Oct. 30, 1886		82		MONTHS		DAYS		HOURS		MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Austria		USA				Baltimore											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Catonsville		House In Pines		--		--											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
Maryland		---		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		917 Wildwood Pkwy.		21229							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIEN NAME		First		Middle		Last			
Joseph		Benyo						A Joseph Benyo, Jr.		5934		Robindale Rd.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
		213-01-7276		A Joseph Benyo, Jr.		21228											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124		ARTERIO - SCLEROTIC CARDIO - VASC. DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		3 YRS.											
DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 10/24, 1964, to 2/23, 1969, that (I) (we) last saw the deceased alive on 2/20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
Paul R. Ziegler		2/25/69		Paul R. Ziegler		200 Chestnut Hill Dr., Balto.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)											
Burial		2/26/69		Loudon Park Cemetery		Baltimore, Maryland											
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Witzke, 4101 Edmondson Ave., Balto., Md.		FEB 25 1969		Charles Judge													

01310

01310

ST 1069

1961

Barro, St.

Joseph

Field

White

Oct. 30, 1961

Religious

USA

Barro, St.

House in line

Barro, St.

Religious

St. 1069

Joseph

Barro, St.

St. 1069 A Joseph Barro, St. 1069

St. 1069

St. 1069

London East Cemetery, Barro, St.

St. 1069

St. 1069, Barro, St. 1069

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)  
30M REV. 1/66

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
01956										
01951										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M	
William			Raymond			Berry			February 5, 1969	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Male		Negro		April 20, 1887			81 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Balto. Co., Md.		U.S.A.				Baltimore				Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
99 Exposed or was exposed to hospital infection			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Farming	
13b. COUNTY			13e. STREET AND NUMBER							
Maryland			Longnecker Road							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Unknown			Rachel			Charms				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No			212-38-4618		Joseph Berry			3816 Ridgewood Ave. Balto 15, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage										2 hrs
4319 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
Hypertrophic atherosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1-1-1969, to 2-5-1969, that (I) (we) last saw the deceased alive on 2-4-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										22c. DATE SIGNED
James G. Saffell										2-8-69
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS
James G. Saffell MD										Reisterstown Md
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2/8/69		Piney Grove Cemetery		Boring, Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
H. J. Edhardt		Owings Mills, Md.		DATE FEB 10 1969		Judge				



15210

15210

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MARY ELIZABETH BEVAN				2	Month	12	Day	69
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS
FEMALE		CAUCASIAN		6-8-17		51		IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				BALTIMORE Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		GREAT BALT MED CENTER		housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland		Harford		Jarrettsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Nelson Mill Rd
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
Edwin		Mary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		212-05-1584		Mr Gordon Bevan		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONJESTIVE HEART FAILURE</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE TUBULAR NECROSIS AND RENAL FAILURE 48-72 hr</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS AND SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>in radiated metastasis of</u> <u>CARCENOMA OF L BREAST WITH METASTASES TO LUNG: ASCESS L LOWER LOBE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2-4-69		carcenoma & abcess in L lower lung-lobeotomy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>69</u> , to <u>2-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Derek A Bruce M.D. CH.B</u>				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2-12-69</u>
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
DEREK A. BRUCE M.D. CH.B				6701 N CHARLES ST, BALT. MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		2/15/69		Belair Memorial Gardens		Belair Maryland		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Leonard J Ruck Inc				Baltimore, Maryland		FEB 13 1969		<u>Charles Judge</u>

82210

1911-12 17-18 1912-13 1913-14 1914-15 1915-16 1916-17 1917-18 1918-19 1919-20 1920-21 1921-22 1922-23 1923-24 1924-25 1925-26 1926-27 1927-28 1928-29 1929-30 1930-31 1931-32 1932-33 1933-34 1934-35 1935-36 1936-37 1937-38 1938-39 1939-40 1940-41 1941-42 1942-43 1943-44 1944-45 1945-46 1946-47 1947-48 1948-49 1949-50 1950-51 1951-52 1952-53 1953-54 1954-55 1955-56 1956-57 1957-58 1958-59 1959-60 1960-61 1961-62 1962-63 1963-64 1964-65 1965-66 1966-67 1967-68 1968-69 1969-70 1970-71 1971-72 1972-73 1973-74 1974-75 1975-76 1976-77 1977-78 1978-79 1979-80 1980-81 1981-82 1982-83 1983-84 1984-85 1985-86 1986-87 1987-88 1988-89 1989-90 1990-91 1991-92 1992-93 1993-94 1994-95 1995-96 1996-97 1997-98 1998-99 1999-00 2000-01 2001-02 2002-03 2003-04 2004-05 2005-06 2006-07 2007-08 2008-09 2009-10 2010-11 2011-12 2012-13 2013-14 2014-15 2015-16 2016-17 2017-18 2018-19 2019-20 2020-21 2021-22 2022-23 2023-24 2024-25 2025-26 2026-27 2027-28 2028-29 2029-30 2030-31 2031-32 2032-33 2033-34 2034-35 2035-36 2036-37 2037-38 2038-39 2039-40 2040-41 2041-42 2042-43 2043-44 2044-45 2045-46 2046-47 2047-48 2048-49 2049-50 2050-51 2051-52 2052-53 2053-54 2054-55 2055-56 2056-57 2057-58 2058-59 2059-60 2060-61 2061-62 2062-63 2063-64 2064-65 2065-66 2066-67 2067-68 2068-69 2069-70 2070-71 2071-72 2072-73 2073-74 2074-75 2075-76 2076-77 2077-78 2078-79 2079-80 2080-81 2081-82 2082-83 2083-84 2084-85 2085-86 2086-87 2087-88 2088-89 2089-90 2090-91 2091-92 2092-93 2093-94 2094-95 2095-96 2096-97 2097-98 2098-99 2099-00 2100-01 2101-02 2102-03 2103-04 2104-05 2105-06 2106-07 2107-08 2108-09 2109-10 2110-11 2111-12 2112-13 2113-14 2114-15 2115-16 2116-17 2117-18 2118-19 2119-20 2120-21 2121-22 2122-23 2123-24 2124-25 2125-26 2126-27 2127-28 2128-29 2129-30 2130-31 2131-32 2132-33 2133-34 2134-35 2135-36 2136-37 2137-38 2138-39 2139-40 2140-41 2141-42 2142-43 2143-44 2144-45 2145-46 2146-47 2147-48 2148-49 2149-50 2150-51 2151-52 2152-53 2153-54 2154-55 2155-56 2156-57 2157-58 2158-59 2159-60 2160-61 2161-62 2162-63 2163-64 2164-65 2165-66 2166-67 2167-68 2168-69 2169-70 2170-71 2171-72 2172-73 2173-74 2174-75 2175-76 2176-77 2177-78 2178-79 2179-80 2180-81 2181-82 2182-83 2183-84 2184-85 2185-86 2186-87 2187-88 2188-89 2189-90 2190-91 2191-92 2192-93 2193-94 2194-95 2195-96 2196-97 2197-98 2198-99 2199-00 2200-01 2201-02 2202-03 2203-04 2204-05 2205-06 2206-07 2207-08 2208-09 2209-10 2210-11 2211-12 2212-13 2213-14 2214-15 2215-16 2216-17 2217-18 2218-19 2219-20 2220-21 2221-22 2222-23 2223-24 2224-25 2225-26 2226-27 2227-28 2228-29 2229-30 2230-31 2231-32 2232-33 2233-34 2234-35 2235-36 2236-37 2237-38 2238-39 2239-40 2240-41 2241-42 2242-43 2243-44 2244-45 2245-46 2246-47 2247-48 2248-49 2249-50 2250-51 2251-52 2252-53 2253-54 2254-55 2255-56 2256-57 2257-58 2258-59 2259-60 2260-61 2261-62 2262-63 2263-64 2264-65 2265-66 2266-67 2267-68 2268-69 2269-70 2270-71 2271-72 2272-73 2273-74 2274-75 2275-76 2276-77 2277-78 2278-79 2279-80 2280-81 2281-82 2282-83 2283-84 2284-85 2285-86 2286-87 2287-88 2288-89 2289-90 2290-91 2291-92 2292-93 2293-94 2294-95 2295-96 2296-97 2297-98 2298-99 2299-00 2300-01 2301-02 2302-03 2303-04 2304-05 2305-06 2306-07 2307-08 2308-09 2309-10 2310-11 2311-12 2312-13 2313-14 2314-15 2315-16 2316-17 2317-18 2318-19 2319-20 2320-21 2321-22 2322-23 2323-24 2324-25 2325-26 2326-27 2327-28 2328-29 2329-30 2330-31 2331-32 2332-33 2333-34 2334-35 2335-36 2336-37 2337-38 2338-39 2339-40 2340-41 2341-42 2342-43 2343-44 2344-45 2345-46 2346-47 2347-48 2348-49 2349-50 2350-51 2351-52 2352-53 2353-54 2354-55 2355-56 2356-57 2357-58 2358-59 2359-60 2360-61 2361-62 2362-63 2363-64 2364-65 2365-66 2366-67 2367-68 2368-69 2369-70 2370-71 2371-72 2372-73 2373-74 2374-75 2375-76 2376-77 2377-78 2378-79 2379-80 2380-81 2381-82 2382-83 2383-84 2384-85 2385-86 2386-87 2387-88 2388-89 2389-90 2390-91 2391-92 2392-93 2393-94 2394-95 2395-96 2396-97 2397-98 2398-99 2399-00 2400-01 2401-02 2402-03 2403-04 2404-05 2405-06 2406-07 2407-08 2408-09 2409-10 2410-11 2411-12 2412-13 2413-14 2414-15 2415-16 2416-17 2417-18 2418-19 2419-20 2420-21 2421-22

1900

6. The following information is provided for the year ended 31/12/2014:

2007-2008

100-443887-100

8 JUL 1965

CONFIDENTIAL

CONFIDENTIAL

1. 2000-2001 3. 2001-2002 4. 2002-2003 5. 2003-2004 6. 2004-2005 7. 2005-2006 8. 2006-2007 9. 2007-2008 10. 2008-2009 11. 2009-2010 12. 2010-2011 13. 2011-2012 14. 2012-2013 15. 2013-2014 16. 2014-2015 17. 2015-2016 18. 2016-2017 19. 2017-2018 20. 2018-2019 21. 2019-2020 22. 2020-2021 23. 2021-2022 24. 2022-2023 25. 2023-2024 26. 2024-2025 27. 2025-2026 28. 2026-2027 29. 2027-2028 30. 2028-2029 31. 2029-2030 32. 2030-2031 33. 2031-2032 34. 2032-2033 35. 2033-2034 36. 2034-2035 37. 2035-2036 38. 2036-2037 39. 2037-2038 40. 2038-2039 41. 2039-2040 42. 2040-2041 43. 2041-2042 44. 2042-2043 45. 2043-2044 46. 2044-2045 47. 2045-2046 48. 2046-2047 49. 2047-2048 50. 2048-2049 51. 2049-2050 52. 2050-2051 53. 2051-2052 54. 2052-2053 55. 2053-2054 56. 2054-2055 57. 2055-2056 58. 2056-2057 59. 2057-2058 60. 2058-2059 61. 2059-2060 62. 2060-2061 63. 2061-2062 64. 2062-2063 65. 2063-2064 66. 2064-2065 67. 2065-2066 68. 2066-2067 69. 2067-2068 70. 2068-2069 71. 2069-2070 72. 2070-2071 73. 2071-2072 74. 2072-2073 75. 2073-2074 76. 2074-2075 77. 2075-2076 78. 2076-2077 79. 2077-2078 80. 2078-2079 81. 2079-2080 82. 2080-2081 83. 2081-2082 84. 2082-2083 85. 2083-2084 86. 2084-2085 87. 2085-2086 88. 2086-2087 89. 2087-2088 90. 2088-2089 91. 2089-2090 92. 2090-2091 93. 2091-2092 94. 2092-2093 95. 2093-2094 96. 2094-2095 97. 2095-2096 98. 2096-2097 99. 2097-2098 100. 2098-2099 101. 2099-2100 102. 2100-2101 103. 2101-2102 104. 2102-2103 105. 2103-2104 106. 2104-2105 107. 2105-2106 108. 2106-2107 109. 2107-2108 110. 2108-2109 111. 2109-2110 112. 2110-2111 113. 2111-2112 114. 2112-2113 115. 2113-2114 116. 2114-2115 117. 2115-2116 118. 2116-2117 119. 2117-2118 120. 2118-2119 121. 2119-2120 122. 2120-2121 123. 2121-2122 124. 2122-2123 125. 2123-2124 126. 2124-2125 127. 2125-2126 128. 2126-2127 129. 2127-2128 130. 2128-2129 131. 2129-2130 132. 2130-2131 133. 2131-2132 134. 2132-2133 135. 2133-2134 136. 2134-2135 137. 2135-2136 138. 2136-2137 139. 2137-2138 140. 2138-2139 141. 2139-2140 142. 2140-2141 143. 2141-2142 144. 2142-2143 145. 2143-2144 146. 2144-2145 147. 2145-2146 148. 2146-2147 149. 2147-2148 150. 2148-2149 151. 2149-2150 152. 2150-2151 153. 2151-2152 154. 2152-2153 155. 2153-2154 156. 2154-2155 157. 2155-2156 158. 2156-2157 159. 2157-2158 160. 2158-2159 161. 2159-2160 162. 2160-2161 163. 2161-2162 164. 2162-2163 165. 2163-2164 166. 2164-2165 167. 2165-2166 168. 2166-2167 169. 2167-2168 170. 2168-2169 171. 2169-2170 172. 2170-2171 173. 2171-2172 174. 2172-2173 175. 2173-2174 176. 2174-2175 177. 2175-2176 178. 2176-2177 179. 2177-2178 180. 2178-2179 181. 2179-2180 182. 2180-2181 183. 2181-2182 184. 2182-2183 185. 2183-2184 186. 2184-2185 187. 2185-2186 188. 2186-2187 189. 2187-2188 190. 2188-2189 191. 2189-2190 192. 2190-2191 193. 2191-2192 194. 2192-2193 195. 2193-2194 196. 2194-2195 197. 2195-2196 198. 2196-2197 199. 2197-2198 200. 2198-2199 201. 2199-2200 202. 2200-2201 203. 2201-2202 204. 2202-2203 205. 2203-2204 206. 2204-2205 207. 2205-2206 208. 2206-2207 209. 2207-2208 210. 2208-2209 211. 2209-2210 212. 2210-2211 213. 2211-2212 214. 2212-2213 215. 2213-2214 216. 2214-2215 217. 2215-2216 218. 2216-2217 219. 2217-2218 220. 2218-2219 221. 2219-2220 222. 2220-2221 223. 2221-2222 224. 2222-2223 225. 2223-2224 226. 2224-2225 227. 2225-2226 228. 2226-2227 229. 2227-2228 230. 2228-2229 231. 2229-2230 232. 2230-2231 233. 2231-2232 234. 2232-2233 235. 2233-2234 236. 2234-2235 237. 2235-2236 238. 2236-2237 239. 2237-2238 240. 2238-2239 241. 2239-2240 242. 2240-2241 243. 2241-2242 244. 2242-2243 245. 2243-2244 246. 2244-2245 247. 2245-2246 248. 2246-2247 249. 2247-2248 250. 2248-2249 251. 2249-2250 252. 2250-2251 253. 2251-2252 254. 2252-2253 255. 2253-2254 256. 2254-2255 257. 2255-2256 258. 2256-2257 259. 2257-2258 260. 2258-2259 261. 2259-2260 262. 2260-2261 263. 2261-2262 264. 2262-2263 265. 2263-2264 266. 2264-2265 267. 2265-2266 268. 2266-2267 269. 2267-2268 270. 2268-2269 271. 2269-2270 272. 2270-2271 273. 2271-2272 274. 2272-2273 275. 2273-2274 276. 2274-2275 277. 2275-2276 278. 2276-2277 279. 2277-2278 280. 2278-2279 281. 2279-2280

6-

2000

11

THE UNIVERSITY OF CHICAGO

4157C

2005/07/16 16:10

2455

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01958		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01953					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR			
Walter J. Blondell					Feb. 26 1969			8:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR			
Male		White		9-28-1908		60 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		USA				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Josephs			Maintenance Foreman			U.S. Gov't		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5607 Ready Ave.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Walter J. Blondell			Naomi Bull								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
Yes			213-07-9101		Margaret G. Blondell Above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe ASCVD (Cerebral Arterial Occlusion in 1967)</u> DUE TO, OR AS A CONSEQUENCE OF (c)									<u>1 1/2 hours</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1958</u> to <u>Feb. 1967</u> , that (I) (we) last saw the deceased alive on <u>18 Feb. 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE ATTENDING PHYS.			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Com H. Kammer</u>										<u>2/28/69</u>	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
William H. Kammer					6011 York Rd., Balto., Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		3-3-69		New Cathedral			Baltimore Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
H.W. Jenkins & Sons Co., Balto., Md.					DATE FEB 28 1969		<u>Charles Judge</u>				

UNITED STATES OF AMERICA

IN SENATE, January 1, 1911.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

ENDING

DECEMBER 31, 1910.

WASHINGTON:

GOVERNMENT PRINTING OFFICE:

1911.

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-68

01959										01954														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Adolphe					W. Blondheim					Month 2 Day 19 Year 69					2:10 P M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Male			White			10/16/88			80 YRS.			MONTHS DAYS HOURS MIN.												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Maryland			U. S. A.						Baltimore Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Lutherville, Md.					College Manor Nursing Home					Artist														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Baltimore, Md.					BALTIMORE					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					3601 Greenway									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Not available					Solomon Blondheim					Not available					Bella Weiner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address														
Yes					WW I					197-14-2993 Dr. Crawford Kirkpatrick 6 E. Eager St.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Carcinoma of the lung.																								
1621 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
(b) DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (the hospital) attended the deceased from September, 19 68, to Present, 19 ____, that (I) (we) last saw the deceased alive on February 13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Crawford N. Kirkpatrick, Jr., M.D.															February 20, 1969									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
Crawford N. Kirkpatrick, Jr., M.D.															6 East Eager St. Baltimore, Md. 21202									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Cremation					Feb. 20, 1969					Green Mount Crematory					Baltimore, Maryland									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204															DATE FEB 21 1969					K. Charles Underwood				

0254

0125

2005

also

五

• •

2004

1. *Staphylococcus aureus*

1

100

17 25 20

and add to number:

250

10. 11. 1910

[illegible]

. . .



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
ADDIE			Lort			BOULDEN			FEB 21 1969		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)		
Female			White			Oct 20 - 1881			87 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		
PENNSYLVANIA			U. S. A.						BALTIMORE Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE			SPRING GROVE STATE HOSP			STORE CLERK			STORE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD-			CECIL			ELKTON			512 N. STREET.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
JOSEPH			LORT			Mc CLEARY			Martha		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			219-22-1576			SISTER			ELKTON MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA.											
401X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) HYPERTENSION											
DUE TO, OR AS A CONSEQUENCE OF											
(c) ARTERIOSCLEROSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
CHRONIC ORGANIC BRAIN SYNDROME											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN 17/69, 1969, to FEB 21, 1969, that (I) (we) last saw the deceased alive on FEB 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
E. Trujillo			FEB 21/69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
EMILIO A. TRUJILLO			SPRING GROVE STATE HOSP.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2/25/69			Sharps Cemetery			Fair Hill Cecil Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Hicks Home for Funerals, Elkton, Md.			FEB 28 1969			Charles Judge					

01882

01880

UNITED STATES OF AMERICA

Date

Name

0-222-127

FEB 2 8 1960

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13-100  
45M - 11-69

01961										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01956									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										7. HOUR									
Margaret L Bowers										Month Day Year Feb. 10, 1969										7:15pm									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			8. YRS.			IF UNDER 1 YEAR			IF UNDER 24 HRS											
Female			White			07-15-84			84						MONTHS			DAYS											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Md.			U.S.						Baltimore																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Catonsville			Spring Grove State Hosp.			NURSE																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Maryland						Baltimore			YES			1933 Breitwert Ave.																	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
George W. Bowers			Sarah E. Flannery																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
			217-18-3628			Spring Grove Hosp. records																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																													
4109 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c) DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from Nov. 6, 1968, to Feb. 10, 1969, that (I) (we) last saw the deceased alive on Feb. 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			DEGREE			ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED																	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
DAVID H. MARIN			22e. ADDRESS			SPRING GROVE STATE HOSP																							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
BURIAL			2/14/69			New Cathedral			BALTIMORE			Md.																	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																				
C.S. MacNabb			301 Frederick Rd			DATE FEB 13 1969			Charles J...																				

81832

OFFICE OF THE

01101

Feb. 10, 1900

George

I

George

George

White

07-12-10

10

Feb. 10, 1900

U.S.

John Grove State Hosp.

Georgetown

Baltimore

Maryland

1900, Baltimore, Md.

George

George

W. Fox

George

011-1-1000

John Grove State Hosp.

Georgetown

Maryland

Baltimore

1900, Baltimore, Md.

George

George

W. Fox

011-1-1000

John Grove State Hosp.

Georgetown

Maryland

Baltimore

1900, Baltimore, Md.

George

George

W. Fox

011-1-1000

John Grove State Hosp.

Georgetown

Maryland

Baltimore

1900, Baltimore, Md.

George

George

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01962

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01957

1. DECEASED-NAME (Type or Print)		First Alvin	Middle L.	Lost Brinkman	2a. DATE KNOWN OF ESTI- DEATH MATED 2/26/69 9:00 AM		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 24, 1915	6. AGE (In years lost birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD February 26	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2601 Lodge Farm Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Welder - Bethlehem Steel Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Oscar		Middle B.		Lost Brinkman		15. MOTHER'S MAIDEN NAME First Henrietta	
						Middle L.	
						Lost Lowery	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WWII 213-09-3357		17. INFORMANT (Mother) Mrs. Henrietta Brinkman, 907 "H" St.		ADDRESS Sparrows Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (c) HEVD							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Theodore C. Patterson		M.D.		22b. DATE SIGNED 2/27/69 3724 Dundalk Ave. Dundalk, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/3/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE MAR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



01957

UNITED STATES DEPARTMENT OF AGRICULTURE

01957

UNITED STATES DEPARTMENT OF AGRICULTURE

Form with multiple sections and handwritten entries. The form includes fields for "Name", "Address", "City", "State", and "Zip". There are also sections for "Remarks" and "Comments". The form is filled out with handwritten text, including "01957" in the top left corner, "01957" in the top right corner, and "01957" in the bottom left corner. The form is dated "01957" in the top right corner. The form is dated "01957" in the bottom left corner. The form is dated "01957" in the bottom right corner. The form is dated "01957" in the bottom right corner.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 10 Film 103/5/69 01963										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01958			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or Print)			First ERNEST			Middle WOODROW			Last BROOKS			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>			Month 19			Day Year			2b. HOUR M		
3. SEX male		4. RACE white		5. DATE OF BIRTH 23 Sept. 1912		6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD February 24, 1969			Month Day Year			2d. HOUR 11:00 P.M.					
7a. BIRTHPLACE (State or foreign country) OHIO			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.														
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beltway				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Gov. Worker				12b. KIND OF BUSINESS OR INDUSTRY Social Sec.											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY A.A.Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 9 Bertram Drive													
14. FATHER'S NAME First Elmer			Middle Brooks			Last			15. MOTHER'S MAIDEN NAME First Tillie			Middle Lowe			Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) W W 11 268-81-8912				17. INFORMANT Thelma A. Brooks, (wife)				ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Werner U. Spitz</u> EXAMINER'S NAME (Type) Werner U. Spitz, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)										22b. DATE SIGNED 2/25/69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 2/28/69				23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.				23d. LOCATION (City or Town) (County) (State) Elkridge R.F.O. Md.											
24. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md. Robert P. Ware										25a. REC'D BY REGISTRAR DATE FEB 28 1969				25b. REGISTRAR'S SIGNATURE Charles Judge									

01855

01855

Name		Address		City		State		Zip	
John Doe		123 Main St		Springfield		Illinois		62760	
Age		Sex		Race		Religion		Marital Status	
35		Male		White		Catholic		Married	
Education		Occupation		Income		Assets		Liabilities	
High School		Teacher		\$15,000		\$20,000		\$5,000	
Social Security		Health Insurance		Life Insurance		Auto Insurance		Home Insurance	
123-456789		ABC Insurance Co		XYZ Life Ins Co		DEF Auto Ins Co		GHI Home Ins Co	
Signature		Date		Witness		Notary		Remarks	
John Doe		10/1/75		Jane Doe		John Smith		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

Dr. Bense / E. H. Thompson

MEDICAL CERTIFICATION

01964												01859											
1. DECEASED-NAME (Type or print) <b>ELIJAH</b> First Middle Last						2a. DATE OF DEATH <b>FEB 1</b> Day <b>1969</b> Month Year						2b. HOUR <b>12:4</b> AM											
3. SEX <b>MALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>Sept 6, 1909</b>			6. AGE (In years last birthday) <b>59</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore County,</b> Md.														
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>WATER MAN</b>				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>ANNE ARUNDEL</b>				13c. CITY OR TOWN <b>SHADYSIDE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER											
14. FATHER'S NAME First Middle Last <b>JAMES BROWN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>CARRIE BROWN</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>218-16-2507</b>				17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Uremia</b> <b>403X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOULAR NEPHROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 mo.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Far Advanced Pulmonary Tuberculosis</b>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>10 Jan</b> , 1968, to <b>1 Feb</b> , 1969, that <del>it</del> (we) last saw the deceased alive on <b>1 Feb</b> , 1969, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>W Newcomer</b>						22c. DATE SIGNED <b>1 Feb 1969</b>																	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>						22e. ADDRESS <b>Mount Wilson, Maryland</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>2-5-1969</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Franklin</b>				23d. LOCATION (City or Town) (County) (State) <b>Heale MD</b>											
24. FUNERAL DIRECTOR <b>William Bense</b>				ADDRESS <b>Calver, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>													

11312

11312

William Wilson

William Wilson

William Wilson

William Wilson, Maryland

William Wilson, Maryland

11312

11312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

X

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
01965					01960					
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR		
Nellie R. Buchanan					Feb 4 1969			2:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		1-23-1898			71			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Johnston, Pa.		USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			5221 Pembroke Avenue			Clerk				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Balto		Balto		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5221 Pembroke Avenue	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
John M. Rankin					Annie Belle Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
NO							Thomas Robertson-5221 Pembroke Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses, multiple										
4339 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1958 to Feb 4, 1969, that (I) (we) last saw the deceased alive on Feb 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Seymour H. Rubin, MD						22c. DATE SIGNED 2/5/69				
22d. PHYSICIAN'S NAME (Type) Seymour H. Rubin, MD						22e. ADDRESS 5410 Park Heights Ave				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			2-8-69		Woodlawn Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR Marion P. Amusement, Balto Md						25a. REC'D BY REGISTRAR DATE FEB 7 1969		25b. REGISTRAR'S SIGNATURE		

11389

CENTRAL OF CALIF.

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389

11389



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>First Margaret Middle M Last Bucher</i>					2a. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>69</i>			2b. HOUR <i>M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Jan. 17 1901</i>			6. AGE (In years lost birthday) <i>68</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>State Rds</i>		
10. CITY OR TOWN OF DEATH <i>Catonsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nsg Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerical</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Marriottsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Marriottsville, Rd.</i>	
14. FATHER'S NAME First <i>Frank P</i> Middle <i>Mc Kenna</i> Last <i></i>					15. MOTHER'S MAIDEN NAME First <i></i> Middle <i></i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service) <i>no</i>			16b. SOCIAL SECURITY NO. <i>219-14-19824</i>		17. INFORMANT Address <i>Marriottsville Md.</i> <i>Patrick J Bucher Marriottsville Rd</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X Metastatic CARCINOMA, generalized</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA OF Right BREAST</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>6'9 months</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>21 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION <i>March, 1962</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CARCINOMA Right BREAST</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>January, 1954</i> , to <i>February 19 1969</i> , that (I) (we) last saw the deceased alive on <i>February 19 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Melvin N. Borden MD</i> DEGREE <i></i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>2/20/69</i>					
22d. PHYSICIAN'S NAME (Type) <i></i>					22e. ADDRESS <i>5000 BALTO NAT'L PIKE BALTO, MD 21224</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-22-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md</i>				
24. FUNERAL DIRECTOR ADDRESS <i>Thomas J Kenny Inc 1600 Hollins St</i>					25a. REC'D BY REGISTRAR <i></i> DATE <i>FEB 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			

MEDICAL CERTIFICATION

2

1

01966

01961

1

90  
03  
1

1981

1981

RECEIVED

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

NOV 15 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Lynn</b>			First <b>G.</b> Middle <b>C.</b> Last <b>CECIL</b>			2a. DATE OF DEATH 2 <sup>Month</sup> 22 <sup>Day</sup> 69 <sup>Year</sup>		2b. HOUR 10:10 <sup>A</sup>		
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH 1/9/22		6. AGE (In years lost birthday) 47 <sup>YRS.</sup>		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.				
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Liquor Mfg.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cockeysville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Ivy Hill Road</b>	
14. FATHER'S NAME First <b>Alan B.</b> Middle <b>Cecil</b> Last <b>Cecil</b>			15. MOTHER'S MAIDEN NAME First <b>Agatha M.</b> Middle <b>Michael</b> Last <b>Michael</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <b>111</b>		17. INFORMANT <b>Family records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chromaphobe adenoma of pituitary</b> <b>2262</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION <b>11/3/68 &amp; 2/18/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pituitary tumor</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/4</b> , 19 <b>69</b> , to <b>2/22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Rudiger Breiteneker</b> DEGREE _____						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/22/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>						22e. ADDRESS <b>6701 N. Charles Street</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Feb. 25, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Towson, Maryland</b>				
24. FUNERAL DIRECTOR <b>John Burns Sons</b> ADDRESS <b>Towson</b>						25a. REC'D BY REGISTRAR DATE <b>MAR 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

Blank lined area for text entry.

Vertical text on the right margin, possibly a date or page number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01968

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

01963

1. DECEASED-NAME (Type or print) <b>GIACOMO</b>		First <b>ANTONIO</b> Middle <b>MIN</b> Last <b>CICHERO</b>		2a. DATE OF DEATH <b>2</b> Month <b>8</b> Day <b>69</b> Year		2b. HOUR <b>9:45</b> PM	
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH <b>August 4, 1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE Co.</b> Md.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CEN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CHEF</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>3835 Beehler Avenue 21215</b>		14. FATHER'S NAME First <b>Giuseppi</b> Middle <b>Cichero</b> Last <b>Maddalena</b>		15. MOTHER'S MAIDEN NAME First <b>Ferrari</b> Middle <b>Ferrari</b> Last <b>Ferrari</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>212 16 3277</b>		17. INFORMANT <b>Baltimore, Md. 21215</b> <b>Mrs. Angela P. Cichero 3835 Beehler Avenue</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> <b>188X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Urinary Bladder with Metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <b>4</b> (this hospital) attended the deceased from <b>NOV. 20, 1969</b> , to <b>FEB. 8, 1969</b> , that <b>4</b> (we) last saw the deceased alive on <b>February 8, 1969</b> , and that in <b>4</b> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M. I. Mansour</b>		DEGREE <b>MD.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/9/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. M. I. Mansour, M.D.</b>		22e. ADDRESS <b>6701 N. CHARLES ST. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 12, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>		ADDRESS <b>4611 Park Heights Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1888

STATE OF DEAN

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01969

01964

1. DECEASED-NAME (Type or print) <b>Gaylord Lee Clark</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1969</b>			2b. HOUR <b>7:45</b> AM								
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Aug. 11, 1883</b>		6. AGE (In years lost, birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>Mobile, Ala.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Stevenson 21153</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>"Margaret Meadows"</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Lawyer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>"Margaret Meadows"</b>					
14. FATHER'S NAME First <b>Gaylord</b> Middle <b>Blair</b> Last <b>Clark</b>			15. MOTHER'S MAIDEN NAME First <b>Lettice</b> Middle <b>Lee</b> Last <b>Smith</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service) <b>WWI</b>			16b. SOCIAL SECURITY NO. <b>218-36-8591</b>			17. INFORMANT Address <b>Mrs. Juliana B. K. Clark (Same)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiac disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>10 yrs</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>1955</b> to <b>death</b> , 19 <b>Feb 2</b> , 19 <b>69</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.														
22b. SIGNATURE <b>Robert E. Mason</b> MD DEGREE			22c. DATE SIGNED <b>6 Feb 1969</b>			22d. PHYSICIAN'S NAME (Type) <b>Dr. Robert E. Mason</b>			22e. ADDRESS <b>9 E. Chase St.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/7/1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas'</b>			23d. LOCATION (City or Town) (County) (State) <b>Garrison Forest. Md.</b>					
24. FUNERAL DIRECTOR <b>I.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. J. Jones</b>						

11552

11552



COPIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

01970

01965

1. DECEASED-NAME (Type or print) First Middle Last <b>Caroline Sophia Clemens</b>			2a. DATE OF DEATH Month Day Year <b>2 16 69</b>		2b. HOUR 12:20 P.M.
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 12, 1882</b>	
6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3208 Texas Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3208 Texas Ave</b>			
14. FATHER'S NAME First Middle Last <b>Sebastian Etzkorn</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Wilhelmina Schott</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-01-6854A</b>		17. INFORMANT Address <b>Mrs. Mildred Tamulonis (Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Cardiovascular Disease</b> <b>4/22</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Endocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>?</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING- <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>18 Jun</b> , 19 <b>67</b> , to <b>16 Feb</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>16 Feb</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Howard Goodman</b>				22c. DATE SIGNED <b>17 Feb 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>Howard Goodman M.D.</b>				22e. ADDRESS <b>8604 Harford Rd Baltimore, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/19/69.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 17 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>01971</div> <div> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 </div> </div>										<div> <div>CERTIFICATE OF DEATH</div> <div>01966</div> </div>						
1. DECEASED-NAME (Type or print)			First <b>GEORGE</b>			Middle <b>MELVIN</b>			Last <b>COLSON</b>			2a. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>11</b> Year <b>1969</b>			2b. HOUR <b>6:15</b> <sup>PM</sup>	
3. SEX <b>MALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>JANUARY 6, 1907</b>			6. AGE (In years last birthday) <b>62</b> YRS.			IF UNDER 1 YEAR MONTHS <b>61</b> DAYS		IF UNDER 24 HRS HOURS <b>61</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.							
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOSPITAL VETERANS ADMINISTRATION</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE PAINTER</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>WOODSTOCK</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>OLD COURT ROAD</b>							
14. FATHER'S NAME First <b>GEORGE W</b> Middle <b>COLSON</b> Last						15. MOTHER'S MAIDEN NAME First <b>ANNE E</b> Middle <b>HUDSON</b> Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II 213 18 3332</b>			17. INFORMANT Address <b>CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/11/69</b> , 19____, to <b>2/11/69</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/11/69</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did not see) view the body after death.																
22b. SIGNATURE <b>Madhav D. Barhanpurkar</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED <b>2 12 69</b>						
22d. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M. D.</b>										22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>2-14-69</b>			23c. NAME OF CEMETERY OR CREMATOR <b>Good Shepard Cem BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>Ellicott City, Howard Co.; Md. BALTIMORE, MARYLAND</b>							
24. FUNERAL DIRECTOR ADDRESS <b>LORING BYERS, RANDALLSTOWN, MD</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 17 1969</b>			25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>							

• • • НА ПУТИ К НАМ



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>01972</div> <div> <div>4</div> <div>1</div> </div> <div> <div>00</div> <div>03</div> <div>1</div> </div> <div> <div>2</div> <div>1</div> </div>												<div>01967</div>											
<div> <div>1. DECEASED-NAME (Type or print)</div> <div>First</div> <div>Grace</div> </div> <div> <div>2a. DATE OF DEATH</div> <div>Month</div> <div>February</div> <div>Day</div> <div>26</div> <div>Year</div> <div>1969</div> </div> <div> <div>2b. HOUR</div> <div>M</div> </div>																							
<div>3. SEX</div> <div>Female</div>				<div>4. RACE</div> <div>White</div>				<div>5. DATE OF BIRTH</div> <div>Feb. 10, 1914</div>				<div>6. AGE (In years last birthday)</div> <div>55</div> <div>YRS.</div>											
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>Pennsylvania</div>				<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U. S. A.</div>				<div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>				<div>9. COUNTY OF DEATH</div> <div>Baltimore</div> <div>Md.</div>											
<div>10. CITY OR TOWN OF DEATH</div> <div>Dundalk</div>				<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>7006 Fait Ave.</div>				<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Housewife</div>				<div>12b. KIND OF BUSINESS OR INDUSTRY</div>											
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Maryland</div>				<div>13b. COUNTY</div> <div>Baltimore</div>				<div>13c. CITY OR TOWN</div> <div>Dundalk</div>				<div>13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>14. FATHER'S NAME</div> <div>First</div> <div>Henry</div> <div>Middle</div> <div></div> <div>Last</div> <div>Fillman</div>				<div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Etta</div> <div>Middle</div> <div></div> <div>Last</div> <div>?</div>																			
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)</div> <div>No</div>				<div>16b. SOCIAL SECURITY NO.</div> <div>219-22-0840</div>				<div>17. INFORMANT (Husband)</div> <div>Mr. V. W. Compton, 7006 Fait Ave. Balto. Md.</div>				<div>Address</div> <div>21224</div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Metastatic carcinoma of colon</div> <div>1538</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO, OR AS A CONSEQUENCE OF (b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF (c)</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>12 months</div>																							
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div>																							
<div>19a. DATE OF OPERATION</div>				<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>				<div>20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>				<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>											
<div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div>				<div>21b. TIME OF INJURY</div> <div>HOUR A.M.</div> <div>Month</div> <div>Day</div> <div>Year</div> <div>P.M.</div> <div>19</div>				<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div>															
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/></div>				<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</div>				<div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div>															
<div>22a. I certify that (I) (this hospital) attended the deceased from 2/11/69, 19__, to 2/24/69, 19__, that (I) (we) last saw the deceased alive on 2/24/69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div>																							
<div>22b. SIGNATURE</div> <div>W. E. Baermann</div> <div>DECEASED</div> <div>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div> <div>22c. DATE SIGNED</div> <div>2/27/69</div>																							
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>W. E. Baermann</div> <div>M.D.</div> <div>22e. ADDRESS</div> <div>3401 Dundalk Ave. Baltimore, Md.</div>																							
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>23b. DATE</div> <div>3/1/69</div>				<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Oak Lawn Cemetery</div>				<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Baltimore, Maryland</div>											
<div>24. FUNERAL DIRECTOR</div> <div>John J. Duda, 7922 Wise Ave. Dundalk, Md.</div> <div>ADDRESS</div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>MAR 3 1969</div> <div>25b. REGISTRAR'S SIGNATURE</div>																							

73219

97810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
WILLIAM EDW. CONROY						Feb. 21st, 1969			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		Feb. 29th, 1895			73		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto. Md.		U USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson Balto. Co.			St. Joseph Hospt.			Bgt. (ret) Balto Police			Dept.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Balto.		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6301 Yorkshire Dr
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James Conroy			Mary McDonough						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
yes			WW-1		Mrs. Marie E. Conroy-6301 Yorkshire Dr.-04				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crook's Thrombosis</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Arteriosclerotic Heart Dis</u>									3 yrs
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>66</u> , to <u>2-21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>10-8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Wyman K. Wong, M.D.</u>						22c. DATE SIGNED <u>2-22-69</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Wyman K. Wong, M.D.						6801 Belair Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2/24/69		Holy Redeemer Cem.		Balto		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home-6500 York Rd. 21212						FEB 26 1969		<u>John J. Judge</u>	

01888

RECORDS OF DEATH

01875

Feb. 21, 1900

ATLANTA, GA.

Belmont, Wm. H. 1861  
Wife 1861  
Feb. 21, 1900 73

London, Wm. H. 1861  
Wife 1861  
Feb. 21, 1900 73

James, Wm. H. 1861  
Wife 1861  
Feb. 21, 1900 73

Printed by the Atlanta Journal  
2/21/00  
No. 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
01974									
01969									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Amos			Wilson			Cook			3 P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. YRS.
Male		Cau.		5-14-1887			81		01
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Adams Co. Pa.			U.S.A.					Baltimore Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			815 W. Joppa Rd			Ret Steel Roller			Eastern Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Baltimore			Towson		815 W. Joppa Road 4	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Josiah			Cook			Julia Stanley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			212-03-8402			Orville W. Benedict Jr. 815 Joppa Road 4			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 31, 1967</u> , to <u>Feb 22, 1969</u> , that (I) (we) lost saw the deceased alive on <u>OCT 28 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Larry G. Tilley M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>Larry G. Tilley, M.D.</u>								22e. ADDRESS <u>1713 Taylor Ave. Baltimore, MD. 21234</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-25-1969		Dulaney Valley Cemetery		Cockeysville, Balto. Md		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home 7401 Belair Road 21236						DATE FEB 26 1969		<u>Richard J. Jones</u>	

23810



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01975		01970	
1. DECEASED-NAME (Type or print) <b>ETHEL</b>		First Middle Last <b>B. COOLIDGE</b>	
3. SEX <b>Female</b>		4. RACE <b>Cau.</b>	
70. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC</b>	
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Pennsylvania</b>		13c. CITY OR TOWN <b>Pittsburg</b>	
14. FATHER'S NAME First Middle Last <b>Harry H. Byram</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lillie VanKirk</b>	
160. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>192-05-5465</b>	
17. INFORMANT <b>J.K.Ebbert</b>		Address <b>1441 Squirell Hill Ave. 15213</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive and arteriosclerotic heart disease</b> <b>4121</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease; massive hiatus hernia</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/5/</b> 19 <b>69</b> , to <b>2/7</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/7/</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Rudiger Breitenecker</i>		22c. DATE SIGNED <b>2/7/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breitenecker, M.D.</b>		22e. ADDRESS <b>Greater Baltimore Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-10-1969</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Allegheny Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pittsburg, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks</b>		25. REC'D BY REGISTRAR <b>FEB 10 1969</b>	
Towson 1050 York Rd. 21204		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

07814

OFFICIALS' SIGNATURE

07814

1001

1. The first part of the document is a list of names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

2. The second part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

3. The third part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

4. The fourth part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

5. The fifth part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

6. The sixth part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

7. The seventh part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

8. The eighth part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

9. The ninth part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

10. The tenth part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full, including the street, city, and state.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

01976

01971

1. DECEASED-NAME (Type or print) <b>Jeanette D Costanza</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>69</b>			2b. HOUR <b>5:35</b> M	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>10-18-98</b>		6. AGE (In years last birthday) <b>70</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Ind</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto Co. Gen Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ind</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>P</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Nicholas</b> Middle <b>Fratantono</b> Last <b>Flynn</b>		15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Flynn</b> Last <b>Flynn</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.	
17. INFORMANT <b>Chart</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute M.I.</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.H.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-8-1969</b> , to <b>2-11-1969</b> , that (I) (we) last saw the deceased alive on <b>2-11-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. Baren Calin</b>				22c. DATE SIGNED <b>2-11-69</b>		22d. PHYSICIAN'S NAME (Type) <b>BARBU CALIN</b>	
22e. ADDRESS <b>21 S. St. John's Lane Ellerslie</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2/13/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>E. S. MALNABB</b>				25a. REC'D BY REGISTRAR <b>21228</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

Nicholas  
Richardson  
Belle &  
East Bend (land)  
Tyrone

Christ  
~~John~~ Jacob  
Belle &  
East Bend (land)  
Tyrone

W  
10-18-78  
to  
Gaston  
2  
11  
27

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

01977												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												01972																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																															
1. DECEASED-NAME (Type or Print)						First		Middle		Last				2a. DATE KNOWN OF DEATH				<input checked="" type="checkbox"/> Month		Day		Year		2b. HOUR																							
ROBERT L. CRAUMER														2				7		1969		11:40																									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				Month		Day		Year		2d. HOUR																									
M		W		JULY 24 1895		73 YRS.		MONTHS		DAYS		2				7		1969		12:45																											
7a. BIRTHPLACE (State or foreign country)						7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH								Md.																									
Maryland						USA								BALTIMORE																																	
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY																													
ESSEX						DR PLATT 400 EASTERN BLVD						Retired police work																																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER																																			
MD						BALTO		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		907 LUTZ																																			
14. FATHER'S NAME						First		Middle		Last				15. MOTHER'S MAIDEN NAME						First		Middle		Last																							
Edgar Craumer														Mary										not known																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS																													
Thought to be 1912						217 05 3226						Harold Patrick						907 Lutz Ave. Baltimore, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																			
PART I. DEATH WAS CAUSED BY:																																															
IMMEDIATE CAUSE (a)												A-S-C-V-DISEASE																																			
4124																																															
DUE TO, OR AS A CONSEQUENCE OF																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b)																																			
												DUE TO, OR AS A CONSEQUENCE OF																																			
												(c)																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																															
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																							
												None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY Month, Day, Year												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
												19																																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)												21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
22b. DATE SIGNED																																															
2/8/69																																															
22c. CHIEF MEDICAL EXAMINER												22d. DEPUTY MEDICAL EXAMINER																																			
M. B. Davis												M. B. Davis																																			
22e. ADDRESS (Street, city, town, county)												22f. ADDRESS (Street, city, town, county)																																			
6800 HORN LANE, DUNDALK MD 21222												6800 HORN LANE, DUNDALK MD 21222																																			
23a. BURIAL, CREMATION, REMOVAL (Specify)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)											
BURIAL												2/10/69												CHESTER												CHESTER TOWN MD											
24. FUNERAL DIRECTOR												ADDRESS												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
J. Willis Wells												CHESTER TOWN MD												FEB 13 1969												J. Charles Judge											

01273

FEB 13 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undertaker, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>EDNA MAUD CRUZEN</b>						2a. DATE OF DEATH Month Day Year <b>Feb. 20 69</b>			2b. HOUR <b>2:20</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-9-1878</b>			6. AGE (In years lost birthday) YRS. <b>90</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.						
10. CITY OR TOWN OF DEATH <b>Lutherville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>College Manor</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3025 N. Calvert St.</b>				
14. FATHER'S NAME First Middle Last <b>Robert Richard Carman</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Elizabeth Griffin</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-44-1520</b>		17. INFORMANT Address <b>Mrs. Mary G. Erlandson Towson, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4409</b> <b>Inter-sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>1950</b> <b>Feb. 16 1969</b>		22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , to <b>Feb. 16 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb. 16 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. William G. Helfrich</b>		22c. DATE SIGNED <b>2-20-69</b>		22d. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrich</b>		22e. ADDRESS <b>5006 Roland Ave., Balto., Md.</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-22-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville Balto., Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>				
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>Feb 24 1969</b>		25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

01573

01573

*Antisocialism*

*June 69*

*1992*

*Dr. B. F. ...*

*2-30-69*

*X*

*... ..*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #15, Film G420 1/12/70 km		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01974	
01979		Item #2a, Film G420 Verified by Doctor, 1/12/70 km			
1. DECEASED-NAME (Type or print)		First Mark	Middle Paige	Last CULVER	2a. DATE OF DEATH Month 2 Day 10 Year 69
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 1, 1959	6. AGE (In years last birthday) 9 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen	
14. FATHER'S NAME First Royce Middle Eugene Last CULVER		15. MOTHER'S MAIDEN NAME First Dorothy Middle May Last BAILEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no	
16b. SOCIAL SECURITY NO. ----		17. INFORMANT Rosewood Records		Address Owings Mills, 21117	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 7431 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of Gastric Contents</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Grand Mal Seizure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>terminal</u> <u>terminal</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>institutionalized 4 months, microcephaly</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/4/68</u> , 19 <u>68</u> , to <u>2/10/</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard A. Jones</u>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2/11/69</u>	
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22e. ADDRESS Rosewood State Hosp., Owings Mills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Feb. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Bristol Cemetery	
24. FUNERAL DIRECTOR <u>H. J. Schardt</u>		ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1969	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01980

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01975

1. DECEASED-NAME (Type or Print) <b>William E. Curran</b>			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>2/24/69</b> <b>4:30 PM</b>			2b. HOUR				
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>8/13/14</b>	6. AGE (in years lost birthday) <b>54 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>2/24/69</b> Year <b>19</b>			2d. HOUR <b>4:30 PM</b>	
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>400 S. Taylor Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Briller</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Kennecott</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3528 E. Fairmount Ave.</b>	
14. FATHER'S NAME <b>Edward</b>				15. MOTHER'S MAIDEN NAME <b>Mary</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Anna Curran, 3528 E. Fairmount Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation by Hanging</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Theo C. Patterson</b>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2/27/69</b>	
EXAMINER'S NAME (Type) <b>THEO. C. PATTERSON</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/27/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Joseph N. Zannino</b>				ADDRESS <b>263 S. Conkling St.</b>			25a. REC'D BY REGISTRAR <b>FEB 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>ANDREW HANSON DAYHOFF</b>						2a. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>1969</b>			2b. HOUR <b>7:45</b> P M		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 23, 1886</b>			6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shadynook Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Weaver-Woolen Mill</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>(W. J. Dickey)</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>943 Cella Avenue</b>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-09-6367 A</b>		17. INFORMANT Address <b>Ellicott City Md. 21043</b> <b>Mrs. Dorothy Toy 943 Cella Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac Arrest.</b> <b>471X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonitis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Influenza.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic Cardiovascular Disease.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-4</b> , 19 <b>68</b> , to <b>2-4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>						DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-5-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>[Name]</b>						22e. ADDRESS <b>[Address]</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/8/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Ellicott City, Md.</b>				
24. FUNERAL DIRECTOR <b>Easton Funeral Home</b>				ADDRESS <b>Catonsville</b>		25a. REC'D BY REGISTRAR <b>Feb 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

01510

RECEIVED

01510

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/66

01982										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01977																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
IRENE										DEISLER										Month 2 Day 6 Year 69										8:20 A M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										Sept. 14, 1890										78 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																				Md.									
Md.										U.S.A.																				Baltimore																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Baltimore										Shawnee										Housewife										Home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md.										Baltimore										City										YES										2221 E. Jefferson St.																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
																				Henry Deisler										1901 Logwood Rd																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										CVA, old and new										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
4320																				DUE TO, OR AS A CONSEQUENCE OF																				2 year																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										LEFT Carotid Artery Occlusion										2 year																													
										(c)										Generalized Arteriosclerosis										Years																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Hypertension										Abdominal Aortic Aneurysm																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 4-8-1968, to 2-6-1969, that (I) (we) lost saw the deceased alive on 2-6-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Cesar Valle Cervero										2-6-69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
CESAR VALLE CAVERO										8629 Liberty Rd																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										Feb. 18-1969										Parkwood Cemetery										Baltimore Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Farley Coronagh Funeral Home										Baltimore Md.										DATE FEB 13 1969										Charles Judge																													

01871

REMARKS ON BOARD

01871

These notes were taken from the log of the ship "Albatross" during her voyage to the Hawaiian Islands in 1859. The ship was commanded by Lieutenant James W. Smith, and the notes were written by the naturalist, Alexander Wetmore. The notes describe the various islands visited, the natural history of the islands, and the activities of the crew. The notes are written in a cursive hand and are somewhat faded. The text is as follows:

These notes were taken from the log of the ship "Albatross" during her voyage to the Hawaiian Islands in 1859. The ship was commanded by Lieutenant James W. Smith, and the notes were written by the naturalist, Alexander Wetmore. The notes describe the various islands visited, the natural history of the islands, and the activities of the crew. The notes are written in a cursive hand and are somewhat faded. The text is as follows:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First. LOUIS		Middle		Last DETRICK		2a. DATE OF DEATH 2 Month 22 Day 69 Year 9 <sup>20</sup> a M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH FEBRUARY 24, 1897		6. AGE (In years lost, birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Co. Md.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CEN.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN 21204		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1422 E. Joppa Road	
14. FATHER'S NAME First PETER		Middle DETRICK		Last		15. MOTHER'S MAIDEN NAME First MARY		Middle SCHAFFER Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 217 03 8492		17. INFORMANT Address MRS. VIRGINA DETRICK 1422 E. JOPPA ROAD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4419 LEAKING AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 2/21/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Leaking Aortic Aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/21, 1969, to 2/22, 1969, that (I) (we) last saw the deceased alive on February 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Vasudeva		M.B.; B.S. DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/22/69			
22d. PHYSICIAN'S NAME (Type) Dr. R. VASUDEVA		MB ; BS		22e. ADDRESS 6701 N. CHARLES ST. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/25/69		23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL		23d. LOCATION (City or Town) (County) (State) TOWSON BALTO. CO., MARYLAND			
24. FUNERAL DIRECTOR WM. E. JOHNSON 8521 LOCH RAVEN BLVD. 21204				25a. REC'D BY REGISTRAR DATE FEB 27 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

87810

OFFICE OF THE SECRETARY OF DEFENSE

87810

TO: THE SECRETARY OF DEFENSE  
FROM: THE SECRETARY OF DEFENSE  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

11. [Illegible]  
12. [Illegible]  
13. [Illegible]  
14. [Illegible]  
15. [Illegible]  
16. [Illegible]  
17. [Illegible]  
18. [Illegible]  
19. [Illegible]  
20. [Illegible]

21. [Illegible]  
22. [Illegible]  
23. [Illegible]  
24. [Illegible]  
25. [Illegible]  
26. [Illegible]  
27. [Illegible]  
28. [Illegible]  
29. [Illegible]  
30. [Illegible]

31. [Illegible]  
32. [Illegible]  
33. [Illegible]  
34. [Illegible]  
35. [Illegible]  
36. [Illegible]  
37. [Illegible]  
38. [Illegible]  
39. [Illegible]  
40. [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-64

01984										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										01979									
Item 10 Film G409 2/14/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) <b>AMALIE (MOLLIE) DIMICK</b>					2a. DATE OF DEATH Month <b>Feb.</b> Day <b>6</b> Year <b>1969</b>					2b. HOUR <b>M</b>																			
3. SEX <b>F</b>			4. RACE <b>W</b>			5. DATE OF BIRTH <b>July-8-1895</b>			6. AGE (In years lost birthday) <b>73</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>														
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Balto.</b>																				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1311 Longview Ave.</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>					13b. COUNTY <b>Balto</b>					13c. CITY OR TOWN <b>Balto</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>904 S. Baylis St</b>													
14. FATHER'S NAME First <b>Frederick</b> Middle <b>Sibert</b> Last <b>?</b>					15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>?</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b>B 215-01-7670</b>					17. INFORMANT <b>Mrs. Anna Smith</b>					Address <b>1311 Longview Ave</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC P. V. DISEASE</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>2/6</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>Benjamin Highstein M.D.</b>										DEGREE <b>M.D.</b>					22c. DATE SIGNED <b>2/17/69</b>														
22d. PHYSICIAN'S NAME (Type) <b>DR. BENJAMIN HIGHSTEIN</b>										22e. ADDRESS <b>121 S. HIGHLAND AVE BALTIMORE, MD. 21224</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE <b>Feb. 10-1969</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>														
24. FUNERAL DIRECTOR <b>Helma A. Hoffmann</b>										ADDRESS <b>3218 Hudson St</b>					25a. REC'D BY REGISTRAR DATE <b>FEB 10 1969</b>					25b. REGISTRAR'S SIGNATURE <b>William A. Judge</b>									

01832

01832

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01985

01980

1. DECEASED-NAME (Type or print) <b>RALPH HENDERSON DORSETT</b>			2a. DATE OF DEATH <b>2</b> Month <b>21</b> Day <b>69</b> Year			2b. HOUR <b>8:25 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH <b>2-7-14</b>		6. AGE (In years last birthday) <b>55</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE CO.</b> Md.	
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Gr. Balto. Medical Cent.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ordinance Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>7825 Clarksworth Place</b>		14. FATHER'S NAME First Middle Last <b>Henry Grady Dorsett</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Sankey Henderson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>215-24-6452</b>		17. INFORMANT <b>Mrs. Beryl T. Dorsett</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>FOLLOWED BY CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>2-4-69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>HIATUS HERNIA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1969</b> , <b>Feb. 21, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb. 21, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M. A. Mansour</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-21-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>MAHMOUD I. MANSOUR</b>				22e. ADDRESS <b>6701 N. Charles St. G.B.M.C. Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/25/69.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 24 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

OFFICE OF THE SECRETARY OF DEFENSE

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

1-7-54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3736943

01986

CERTIFICATE OF DEATH

01981

1. DECEASED-NAME (Type or print) <b>JAMES</b>			First Middle Last <b>J DORSEY</b>			2a. DATE OF DEATH Month Day Year <b>February 17 1969</b>			2b. HOUR A.M. <b>5:10</b>		
3. SEX <b>Male</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>Sept. 16, 1894</b>			6. AGE (In years last birthday) <b>74</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Fort Howard</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Veterans Administration Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Parking Lot Attendant</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>812 W. Lexington Street</b>			14. FATHER'S NAME First Middle Last <b>Henry - - - DORSEY</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Miarh - - - Madden</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>			(If yes give war or dates of service) <b>WW-1</b>			16b. SOCIAL SECURITY NO. <b>213 16 57 02</b>			17. INFORMANT Address <b>Clinical Rcds VA Hospital, Fort Howard, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEMORRHAGIC PANCREATITIS</b> <b>5770</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>SYPHILITIC AORTITIS WITH CARDIOMEGLY. CHRONIC UREMIA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 4</b> , 19 <b>69</b> , to <b>Feb. 17</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 17</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.											
22b. SIGNATURE <b>Madhav D. Barhanpurkar</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>2/17/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M.D.</b>						22e. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2-20-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>						BY REGISTRAR <b>Feb 19 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

[illegible]

1005 W. 10th St. S. Minneapolis, Minn. 55404



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 17-69

MEDICAL CERTIFICATION

01987				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				01982							
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
JESSE						M.		DUNGAN		Month 2 Day 4 Year 69		12:45 AM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		6/11/92				76 YRS.		MONTHS		DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.			
MARYLAND		U.S.A.				BALTIMORE COUNTY,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		VET. ADM. HOSP. FT HOWARD, MD.				MACHINIST				Tool					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
MARYLAND				BALTIMORE				114 E. Fort Avenue							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
JOHN						DUNGAN		MARGARET						THOMPSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (specify) (If none given or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address							
YES		WW I		216 07 22 35		CLIN. RECORDS, VA HOSP. FT HOWARD, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA, LEFT</u> <u>481X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CEREBRAL VASCULAR ACCIDENT, OLD</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (1) (this hospital) attended the deceased from <u>1/19/69</u> , 19____, to <u>2/4/69</u> , 19____, that (1) (we) last saw the deceased alive on <u>2/4/69</u> , 19____, and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED							
<u>Peter V. Juvan</u>								2/4/69							
22d. PHYSICIAN'S NAME (Type)		PETER V. JUVAN, M. D.				22e. ADDRESS									
						VAH FORT HOWARD, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)			
BURIAL		2 7 69		GLEN HAVEN				GLEN BURNIE, MARYLAND							
24. FUNERAL DIRECTOR															
MC COLLY FUNERAL HOME 124 E. FORT AVE. BALTIMORE, MD.															
25a. REC'D BY REGISTRAR FEB 6 1969															
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>															

01383

CENTRE OF DEATH

01383

ALL POST HUMAN, HUMAN

POST HUMAN, HUMAN

ALL POST HUMAN, HUMAN

ALL POST HUMAN, HUMAN

ALL POST HUMAN, HUMAN

ALL POST HUMAN, HUMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MEDICAL CERTIFICATION

01988		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		01983	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <i>Blanche Durham</i>		First <i>ELIZABETH</i> Middle <i>TH</i> Last		2a. DATE OF DEATH Month <i>Feb.</i> Day <i>7</i> Year <i>1969</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		2b. HOUR <i>12:45</i> M	
5. DATE OF BIRTH <i>4-24-1882</i>		6. AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		IF UNDER 24 HRS. HOURS _____ MIN. _____	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County</i> Md.			
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesapeake Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <i>6405 Banbury Rd. Baltimore, Md.</i>		13b. CITY OR TOWN <i>Baltimore</i>	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <i>6405 Banbury Road</i>		14. FATHER'S NAME First <i>James</i> Middle <i>Challis</i> Last <i>Bavington</i>	
15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>ONION</i> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>217-48-7504</i>	
17. INFORMANT <i>F. Russell Durham</i>		18. ADDRESS <i>5303 St. Georges Ave. Balto. Md. 21212</i>		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 10, 1960</i> , to <i>Feb 7, 1969</i> , that (I) <del>(we)</del> lost saw the deceased alive on <i>Feb 7, 1969</i> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <i>(did)</i> view the body after death.					
22b. SIGNATURE <i>Laurence C. Post M.D.</i>		DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/7/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>LAURENCE C. POST</i>		22e. ADDRESS <i>6805 York Rd. Baltimore 21212 Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/9/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>William Watters Mem. Coptown, Harford, Md.</i>	
24. FUNERAL DIRECTOR <i>Charles E. Kurtz</i>		ADDRESS <i>Jarrettsville, Md.</i>		25a. RECEIVED BY REGISTRAR <i>FEB 10 1969</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

01883

01883

4/24/1982

55

Location

6425 Highway Road

Location

James G. Davis

201 222-2222

201 222-2222

01989

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Marie L. Eberling</b>			2a. DATE OF DEATH <b>FEB</b> Month <b>11</b> Day <b>1969</b> Year			2b. HOUR <b>6 A</b> M					
3. SEX <b>F.</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3 - 22 - 05</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto</b>					
10. CITY OR TOWN OF DEATH <b>Arbutus</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2013 Sulphur Spring Rd</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2013 Sulphur Spring Rd</b>		
14. FATHER'S NAME First Middle Last <b>Ebert</b>			15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-20-2576</b>		17. INFORMANT <b>George W. Eberling, 2013 Sulphur Spring Rd.</b>			Address <b>21227</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>3 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes mellitus ; Osteoporosis, generalized</b>											
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>61</b> , to <b>Feb 11</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-27-</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wm Carl Ebeling MD</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-11-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Ebeling</b>						22e. ADDRESS <b>701 St. Paul St., Mt. Vernon Med. Bldg</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/14/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b>						25a. REC'D BY REGISTRAR <b>FEB 13 1969</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1981

RECEIVED

1981

1981





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and capably filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>WALTER CLYDE EKin Sr</b>					2a. DATE OF DEATH Month <b>Feb</b> Day <b>26</b> Year <b>1969</b>			2b. HOUR <b>1:30 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 19, 1874</b>			6. AGE (In years last birthday) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>214 Glenmore Ave</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired B&amp;O R R</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Auditor</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>214 Glenmore Ave</b>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>705-07-4334</b>		17. INFORMANT Address <b>Alice F. Ekin, 214 Glenmore Ave. Catonsville, Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 <b>to Feb 26, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb 26, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John Nesbitt Jr. MD</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-27-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR</b>					22e. ADDRESS <b>1009 Frederick Rd, Baltimore Md 21228</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-1-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>			23d. LOCATION (City or Town) (County) (State) <b>Ellicott City, Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Higinbotham-Slack Funeral Home, Ellicott City, Md</b>					25a. REC'D BY REGISTRAR DATE <b>MAR 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>				

RECEIVED

011100

11222

[Faint, illegible text and markings, possibly a form or document, with some circular stamps visible.]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01991

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01986

1. DECEASED-NAME (Type or Print) <b>DOROTHY GAYLORD ELLIOTT</b>			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>7</b> Year <b>1969</b>			2b. HOUR <b>5 P.M.</b>				
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>4-4-1908</b>	6. AGE (In years last birthday) <b>60</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Feb</b> Day <b>7</b> Year <b>1969</b>				
7a. BIRTHPLACE (State or foreign country) <b>Dayton, Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto</b> Md.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2130 Southland Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2130 Southland Road #7</b>		
14. FATHER'S NAME First <b>Eugene</b> Middle <b>Gaylord</b> Last <b>Young</b>			15. MOTHER'S MAIDEN NAME First <b>Young</b> Middle <b>Young</b> Last <b>Young</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>290-20-8242</b>			17. INFORMANT <b>Ross A. Elliott</b>			ADDRESS <b>2130 Southland Road #7</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1951</b> IMMEDIATE CAUSE (a) <b>Pelvic Malignancy</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>J. Nelson McKay</b>				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 7, 1969</b>		
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>2-10-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore</b> (County) (State)		23e. REC'D BY REGISTRAR <b>Feb 11 1969</b>		
24. FUNERAL DIRECTOR <b>Marion Armacost</b>				ADDRESS <b>4600 Liberty Hgts. Ave</b>		25a. REC'D BY REGISTRAR <b>Feb 11 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judd</b>		

01880

01880

in, acyl

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

yl, re

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
01992					01987							
1. DECEASED-NAME (Type or print)					First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Sarah					E. Elsby			Feb Month 1 Day 1969		3 4 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Mar 6, 1888			80 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Plymouth, Pa.			USA				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			3713 Oak Avenue			At Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Baltimore		Balto				3713 Oak Avenue			
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last							
John Edwards					Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
NO			170-10-2205D		John C. Elsby-3713 Oak Avenue 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Cerebral ischemia and cerebrovascular accident										F HRS		
436.9 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis										2 yrs		
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis										5 yrs?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1958, to Feb 1, 1969, that (I) (we) lost saw the deceased alive on 2-1-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE H. Gerald Oster MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED Feb 1 1969		
22d. PHYSICIAN'S NAME (Type) H. GERALD OSTER MD										22e. ADDRESS 6821 Reisterstown Road Balto		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2-4-1969		Meadowridge Cemetery			Baltimore, Maryland Md				
24. FUNERAL DIRECTOR Marian Armstrong 4400 Liberty North Balto 21207						25a. REC'D BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE Charles Jones				

MEDICAL CERTIFICATION

78818

MADE IN GERMANY

8818

1955

Y I

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>John</b>		Middle <b>A.</b>		Last <b>Englar Br.</b>		2a. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>1969</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11/27/1870</b>			6. AGE (In years last birthday) <b>98</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				Md.	
10. CITY OR TOWN OF DEATH <b>Rodgers Forge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>400 Dunkirk Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sect. retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Rodgers Forge</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>400 Dunkirk Rd.</b>	
14. FATHER'S NAME First <b>Josiah</b> Middle <b></b> Last <b>Englar</b>			15. MOTHER'S MAIDEN NAME First <b>Caroline</b> Middle <b>Faega</b> Last <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>220 44 5388</b>		17. INFORMANT <b>Mrs. Grace E. Hines</b>			Address <b>400 Dunkirk Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis of the Heart</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b></b> , to <b>2/18</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/15/69</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Walter F. Karfgin M.D.</b>						DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/19/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Walter F. Karfgin</b>						22e. ADDRESS <b>4331 Harford Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/20/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek</b>				23d. LOCATION (City or Town) (County) (State) <b>New Windsor Carroll Md.</b>			
24. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home</b>						ADDRESS <b>6500 York Rd.</b>		25a. RECEIVED BY REGISTRAR <b>FEB 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01888

01888

Enlar St. 2 188

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

11/27/1920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Raymond E. Fair</b>			20. DATE OF DEATH <b>Feb.</b> Month <b>Day 12</b> Year <b>69</b>			2b. HOUR <b>5:25P</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 26, 1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Wood</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Spring Grove State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>pattern maker</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Elkridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1910 Loudon Avenue</b>			
14. FATHER'S NAME First Middle Last <b>Samuel E. Fair</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Agnes Freeburger</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-07-5270</b>		17. INFORMANT <b>Russell E. Fair</b>		Address <b>Md 13110 Midway Ave. Rockville</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>486X Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia left lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic Cardiovascular disease</b> years.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-10-58</b> to <b>2/12</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/12</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Steenhauser</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>2/12/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. JUAN A. PEREZ-BA16SA</b>						22e. ADDRESS <b>Spring Grove State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-15-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>1 Park Dorsey Rd. Howard Md.</b>			
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave. 21229</b>		25a. REGISTRAR <b>FEB 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

01384

01384

Name		Address		City		State	
Garcia, Jose		1234 Main St		New York		NY	
Garcia, Maria		1234 Main St		New York		NY	
Garcia, Juan		1234 Main St		New York		NY	
Garcia, Pedro		1234 Main St		New York		NY	
Garcia, Antonio		1234 Main St		New York		NY	
Garcia, Carlos		1234 Main St		New York		NY	
Garcia, Rafael		1234 Main St		New York		NY	
Garcia, Miguel		1234 Main St		New York		NY	
Garcia, Luis		1234 Main St		New York		NY	

21-21-210

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1 - 69

<div style="display: flex; justify-content: space-between;"> <span>01995</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>01990</span> </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
CHARLOTTE			P			FARLEY			February 18, 1969 11:45P		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
FEMALE		WHITE		OCTOBER 4, 1893			75 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND			U.S.A.				BALTIMORE, Md.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Towson				St. Joseph Hospital			HOMEMAKER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE		PHOENIX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		100 Fair Meadow Rd. #21131	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Wm. Patterson			Agnes Smyth								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) No			16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) No			17. INFORMANT Address					
			217 05 1846B			Dorothy E. Wrightson 11 Fair Meadow Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from February 11, 1969, to February 18, 1969, that (X) (we) last saw the deceased alive on February 18, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lorna G. Gaudiel DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED February 19, 1969			
22d. PHYSICIAN'S NAME (Type) Lorna G. Gaudiel, M.D.								22e. ADDRESS 7620 York Road Towson, Md. #21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		2/22/1969		Dulaney Valley Mem. Gardens Timonium			Balto. Md				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Mitchell Wiedefeld Home 6500 York Rd.						FEB 26 1969		J. Charles Judge			

01320

01320

UNITED STATES OF AMERICA

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

Subscribed and sworn to before me this 1st day of June 1960.

Notary Public for the State of New York  
My Commission Expires June 1, 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>JOHN W FARRELL</b>			First <b>John W</b> Middle <b>Farrell</b> Last <b>Farrell</b>			2a. DATE OF DEATH <b>FEB</b> Month <b>5</b> Day <b>1969</b>		2b. HOUR <b>9:50</b> AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-10-22</b>		6. AGE (In years last birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Balto, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto Co Gen Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Claims Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Balto</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <b>3737 Oak Ave</b>		
14. FATHER'S NAME First <b>John</b> Middle <b>W.</b> Last <b>Farrell, Sr.</b>			15. MOTHER'S MAIDEN NAME First <b>Barbara</b> Middle <b>R.</b> Last <b>Rauch</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>			16b. SOCIAL SECURITY NO. <b>216-14-8487</b>		17. INFORMANT Address <b>Baltimore County General Hospital</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pneumonia, severe, bilateral</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 6</b> , 19 <b>69</b> , to <b>Feb 5</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb 5</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M.H. Davis</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Feb 5 1969</b>		
22d. PHYSICIAN'S NAME (Type) <b>M.H. DAVIS</b>					22e. ADDRESS <b>6512 LIBERTY ROAD 21207</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/8/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery-Baltimore, Md.</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Sterling Funeral Home</b> <b>736 Edmondson Ave.</b> <b>Catonsville, Md 21222</b>					25a. REC'D BY REGISTRAR <b>FEB 10 1969</b>		25b. REGISTRAR'S SIGNATURE		

19915

30012

NO. 1

United States  
of America

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>MARY</i>			First Middle Last <i>Fingerhut</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>28</i> Year <i>69</i>			2b. HOUR <i>10:35</i> M		
3. SEX <i>Female</i>			4. RACE <i>white</i>			5. DATE OF BIRTH <i>2-15-80</i>			6. AGE (In years last birthday) <i>88</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Ireland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>Catonsville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Spring Grove St. Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <i>18445 Rolling Rd.</i>			14. FATHER'S NAME First Middle Last <i>Unknown</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>(If yes give war or dates of service)</i>			17. INFORMANT <i>Harold Bowman - 209 N. Luzerne - Balt.</i>			Address <i>2424</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <i>Myocardial Infarction</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <i>Generalized arteriosclerotic heart disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-17-</i> , 19 <i>68</i> , to <i>2-28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/28/69</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Evelio A. Felipe MD</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>2-28/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>EVELIO-A-FELIPE MD</i>						22e. ADDRESS <i>SPRING-GROVE-STATE HOSPITAL.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>3/5/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>HOLY CROSS</i>			23d. LOCATION (City or Town) (County) (State) <i>KEADON PA.</i>		
24. FUNERAL DIRECTOR <i>E. S. MALNABE</i>						ADDRESS <i>21228</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>		
						DATE <i>MAR 4 1969</i>			25b. REGISTRAR'S SIGNATURE		

22222

22222

22222

22222

22222

22222

22222

22222

22222

22222

22222

22222

22222

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01998

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01993

1. DECEASED-NAME (Type or Print) <i>Frederick Edwin Fisher</i>		2a. DATE OF DEATH MATED <input checked="" type="checkbox"/> <i>Feb 14</i> 19 <i>69</i>		2b. HOUR <i>5:30</i> M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>11 Oct 1900</i>	6. AGE (in years lost birthday) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Troy N. Y.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Baltimore County</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>31 Dowling Circle 21234</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First <i>Frederick</i> Middle <i>Fisher</i> Lost		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Bean</i> Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-09-3022</i>		17. INFORMANT ADDRESS <i>Elsie M. Fisher (Wife) Same</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Undet.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Emphysema - severe</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John C. Hyle</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>2-14-69</i>
EXAMINER'S NAME (Type) <i>JOHN C. Hyle</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) <i>7527 Belvoir Rd Balto 36</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>2/18/1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Eugenia K. Seitz</i>		ADDRESS <i>5209 York Rd. Balto. Md. 21212</i>		25a. REC'D BY REGISTRAR <i>FEB 17 1969</i>
Seitz Funeral Home		25b. REGISTRAR'S SIGNATURE <i>Eugenia K. Seitz</i>		

21210

21210

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>01999</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>01994</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>													
1. DECEASED-NAME (Type or print) <b>ROBERT</b>				First <b>EMORY</b> Middle <b>FISHPAW</b> Last				2a. DATE OF DEATH <b>FEBRUARY</b> Month <b>23</b> , Day <b>1969</b>				2b. HOUR <b>11:15P</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPTEMBER 1, 1900</b>				6. AGE (In years lost birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE,</b> Md.							
1d. CITY OR TOWN OF DEATH <b>TOWSON</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>15 SAM WILL AVE. #21093</b>			
14. FATHER'S NAME First <b>Robert</b> Middle <b>Fishpaw</b> Last				15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Berry</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>215-32-0885</b>		17. INFORMANT <b>Mrs. Ada Fishpaw</b>				Address <b>Same as # 13 E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>February 18 1969</b> , to <b>February 23 1969</b> , that (I) (we) last saw the deceased alive on <b>February 23, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Jaime Punzalan</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>2-24-69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Jaime Punzalan, M.D.</b>				22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-26-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Falls Rd. Methodist</b>				23d. LOCATION (City or Town) (County) (State) <b>Butler Maryland</b>					
24. FUNERAL DIRECTOR <b>Vm. Cook-Brooks Towson, Inc.</b>				ADDRESS <b>Towson, Md. 21204</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>P. Charnick Judge</b>			

10010

UNITED STATES OF AMERICA

DEC 3

NOV 10 1960

RECEIVED

U.S. DEPARTMENT OF JUSTICE

INVESTIGATION

UNIT

SECTION

10

11

12

13

14

15

16

17

18

19

20

21



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00  
30  
4

2

2

02000

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01995

1. DECEASED-NAME (Type or Print)			First <b>Susie</b>			Middle <b>Flanary</b>			Last			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2 17 1969				2b. HOUR M			
3. SEX <b>Female</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Feb. 7, 1987</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 19				2d. HOUR M			
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Balto.</b>							
1d. CITY OR TOWN OF DEATH <b>Dundalk</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2623 Plainfield Rd.</b>								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>---</b>				13c. CITY OR TOWN <b>Baltol</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1523 Filbert St.</b>					
14. FATHER'S NAME First Middle Last <b>----- Shoupe</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Unk.</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT <b>Mrs. Monka</b>				ADDRESS <b>1523 Filbert St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Adtherosclerotic Heart Disease</b> (b) <b>Adtherosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cancer of the Breast</b>																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year Hour A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <b>Jess C. Patterson</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED <b>2/17/69</b>							
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ADDRESS (Street, city, town, or county)																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>FEB. 20, 1969</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Elkridge Howard Co. MD.</b>							
24. FUNERAL DIRECTOR <b>John H. Hahn Funeral Home, 4200 Pennington Ave</b>						ADDRESS						25a. REC'D BY REGISTRAR DATE <b>FEB 20 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

01822

000 02 237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1969

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02001

01996

1. DECEASED-NAME (Type or print) <b>SARAH</b> <b>DORA</b> <b>FRADKIN</b>			2a. DATE OF DEATH Month <b>FEB</b> Day <b>28</b> Year <b>1969</b>			2b. HOUR <b>9:45 P M</b>						
3. SEX <b>F</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>OCT 2, 1917</b>		6. AGE (In years last birthday) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.						
10. CITY OR TOWN OF DEATH <b>Balta</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>#1 Dell Court</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <b>md</b>			13b. CITY OR TOWN <b>Balta</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>#1 Dell Ct</b>					
14. FATHER'S NAME First <b>SAMUEL</b> Middle <b>BERMAN</b> Last <b>BERMAN</b>			15. MOTHER'S MAIDEN NAME First <b>BESSIE</b> Middle <b>BERMAN</b> Last <b>BERMAN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>LINDA FRADKIN</b>			Address <b>1 DELL CT</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma - Gene-</b> <b>2001</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>12-28-1968</b> , to <b>2-28-1969</b> , that (I) (we) last saw the deceased alive on <b>2-28-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Cesar Valle Caverio</b>						DEGREE <b>---</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3-1-69</b>				
22d. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CAVERIO</b>						22e. ADDRESS <b>3629 Liberty Rd</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/2/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mukro-Kodesh</b>			23d. LOCATION (City or Town) (County) (State) <b>Balta md</b>				
24. FUNERAL DIRECTOR <b>Sylvanus S. Lewis</b>						ADDRESS <b>2501 N. 9610 Reisterstown Rd</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Name: [illegible]  
 Sex: [illegible]  
 Age: [illegible]  
 Date of Birth: [illegible]  
 Address: [illegible]  
 City: [illegible]  
 State: [illegible]  
 Zip: [illegible]  
 Telephone: [illegible]  
 Occupation: [illegible]  
 Education: [illegible]  
 Religion: [illegible]  
 Marital Status: [illegible]  
 Number of Children: [illegible]  
 Date of Admission: [illegible]  
 Date of Discharge: [illegible]  
 Discharge Status: [illegible]  
 Discharge Date: [illegible]  
 Discharge Address: [illegible]  
 Discharge City: [illegible]  
 Discharge State: [illegible]  
 Discharge Zip: [illegible]  
 Discharge Telephone: [illegible]  
 Discharge Occupation: [illegible]  
 Discharge Education: [illegible]  
 Discharge Religion: [illegible]  
 Discharge Marital Status: [illegible]  
 Discharge Number of Children: [illegible]



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 18-22a Film 410 Maryland STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01997

1. DECEASED-NAME (Type or Print) <b>GEORGE Lewis <del>XXXX</del> FRANK</b>				2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR OF ESTI- MATED <input type="checkbox"/> Feb. 16, 1969 <b>4:30P.</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>7-23-1940</b>	6. AGE (In years last birthday) <b>28</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7728 Greenview Terrace</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>George</b> Middle <b>L</b> Last <b>Frank</b>		15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>220-36-9755</b>		17. INFORMANT ADDRESS <b>Sharon G. Frank-5207 St. Charles Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post-necrotic cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 5718 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>5207 St. Charles Avenue</b>		City or Town <b>Baltimore</b> County <b>Baltimore</b> State <b>Md</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>2/17/69</b>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ADDRESS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-20-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Marion Armacost Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore, Maryland</b> (County) <b>Baltimore</b> (State) <b>Md</b>	
24. FUNERAL DIRECTOR <b>Marion Armacost-4600 Liberty Hgts. Avenue</b>				25a. REC'D BY REGISTRAR <b>FEB 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Judge</b>	

49-5-5

1,070 miles

NO. 1 I [REDACTED] 7000

612

700

• • • • •

*(continued)*

\_\_\_\_\_

09877

V. M. Ilyashenko, *1900-1988* and *1989*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7 1

02003

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01998

1. DECEASED-NAME (Type or print) <b>ANTHONY L. FRANKLIN</b>			2a. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>22</b> Year <b>1969</b>			2b. HOUR <b>12:40AM</b>							
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>9/16/07</b>		6. AGE (In years last birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.							
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VETERANS ADMIN. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>JANITOR</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>225 CHESTNUT STREET</b>				
14. FATHER'S NAME First Middle Last <b>OSCAR - - FRANKLIN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>HEDDY - - JONES</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>			16b. SOCIAL SECURITY NO. <b>218 07 69 48</b>		17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWNW</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEB. 18, 1969</b> , to <b>FEB. 22, 1969</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>FEB. 22, 1969</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <b>Elsa M. Goris</b>										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2 22 69</b>	
22d. PHYSICIAN'S NAME (Type) <b>ELSA M. GORIS, M. D.</b>					22e. ADDRESS <b>VAH, FT. HOWARD, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-27-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>						
24. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									
25a. ADDRESS <b>COLLICK FUNERAL HOME</b>		25b. ADDRESS <b>2431 E. OLLIVER ST. BALTIMORE, MD.</b>											

8:310

8:310

Handwritten signature or initials, possibly "J. B. Jones".

Handwritten signature or initials, possibly "J. B. Jones".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01999

1. DECEASED-NAME (Type or print) <b>Beulah</b>		First <b>Beulah</b>		Middle <b>-</b>		Last <b>FREY</b>		2a. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>69</b>				2b. HOUR <b>8:20</b> P <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 23, 1909</b>				6. AGE (In years lost birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.							
10. CITY OR TOWN OF DEATH <b>Owings Mills</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Wolfsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>unknown</b>					
14. FATHER'S NAME First <b>Denton</b> Middle <b>C.</b> Last <b>FREY</b>		15. MOTHER'S MAIDEN NAME First <b>Sally</b> Middle <b>M.</b> Last <b>?</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Md. 21117</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5039</b> IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Sinusitis</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b> <b>terminal</b> <b>WKS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <b>12/19</b> , 19 <b>56</b> , to <b>2/20</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>2/20/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Richard A. Jones</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>21 Feb 69</b>							
22d. PHYSICIAN'S NAME (Type) <b>Richard A. Jones</b>		22e. ADDRESS <b>Rosewood State Hospital</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>2-23-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wolfeville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wolfeville, Wash Md.</b>							
24. FUNERAL DIRECTOR <b>Minnoch Funeral Home Smithsburg, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DATE FEB 25 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

01322

RECEIVED

01322

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE



02005

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>BEATRICE</b>			First <b>R.</b> Middle <b>GANN</b> Last			2a. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1969</b>			2b. HOUR <b>10 A.M.</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>W HITE</b>			5. DATE OF BIRTH <b>FEBRUARY 12, 1910</b>			6. AGE (In years last birthday) <b>59</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>COCKEYSVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ALBATON FARM, FALLS ROAD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>COCKEYSVILLE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>ROSENBAUM</b> Last			15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>SAPPERSTEIN</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216-28-7294</b>			17. INFORMANT Address <b>DR. MARK E. GANN, FALLS RD., COCKEYSVILLE 21030</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 1/2 yr.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>arteriosclerosis</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , to <b>2014</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>Feb 24 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph B. Gross</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-24-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>JOSEPH B. GROSS</b>						22e. ADDRESS <b>6911 PARK HEIGHTS AVENUE</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>2-25-69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 26 1969</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

RECEIVED BY THE POST OFFICE AT NEW YORK, N.Y. FEBRUARY 14, 1917

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02006

02002

1. DECEASED-NAME (Type or print) First Middle Last Ora Harvey Garner			2a. DATE OF DEATH Month Day Year 2 19 1969			2b. HOUR 12:30 P.M.	
3. SEX FEM. Fem.		4. RACE Cau.		5. DATE OF BIRTH 8/30/92		6. AGE (In years lost birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 917 Sedgley Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Balt.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER same as #11		14. FATHER'S NAME First Middle Last William Perrow		15. MOTHER'S MAIDEN NAME First Middle Last Ella Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 217-58-4306		17. INFORMANT Welford E. Garner Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerosis C-C.D.</u> last. (c) <u>ga</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 5, 1964</u> , to <u>2/19, 1969</u> , that (I) (we) last saw the deceased alive on <u>2/19, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Cliff Ratliff, Jr.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/19/69	
22d. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.				22e. ADDRESS 4605 EDMONDSON AVE Balt			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/21/69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Woodlawn, Balt. Co., Md	
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks West Inc Balt. Md. 21228				25a. REC'D BY REGISTRAR DATE FEB 24 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

70715

0700112

100

211111

CF 01120

1500, 5000

•

Chlorine

23.65.37

*E. coli* O157:H7

1

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

*Journal of Interpersonal Violence*

[illegible]

— ( ) —

100

2

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

[illegible]

221

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A150  
30M REV. 7/69

| 02007                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |                         |  |                                                                                                                            |                                     |  |  |  | 02002                                                                                                                                                       |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|--|--------------------------------|--------------------------------------------------------------------------------------|--|--------------------------------|--|--|-------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |                         |  |                                                                                                                            |                                     |  |  |  | CERTIFICATE OF DEATH                                                                                                                                        |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>CHARLES CONNER GAUSE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                         |  | First Middle Last                                                                                                          |                                     |  |  |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>23</b> Year <b>1969</b>                                                                                   |                                                      |  |  |                                | 2b. HOUR<br><b>5:20PM</b>                                                            |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | 4. RACE<br><b>White</b> |  |                                                                                                                            | 5. DATE OF BIRTH<br><b>11/25/94</b> |  |  |  |                                                                                                                                                             | 6. AGE (In years<br>last birthday)<br><b>74</b> YRS. |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS |                                                                                      |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Delaware</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                              |                                     |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                      |  |  |                                | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>                                          |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Veterans Administration Hospital</b> |                                     |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Clerk</b>                                                  |                                                      |  |  |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Banking</b>                               |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |                         |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                            |                                     |  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                      |  |  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                |  |  | 13e. STREET AND NUMBER<br><b>3569 4th Street</b>      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Percy Gause</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                         |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Bertie Conner</b>                                                         |                                     |  |  |  |                                                                                                                                                             |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)<br><b>WW I</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>213-10-0740</b>                                                                             |                                     |  |  |  | 17. INFORMANT<br><b>Med. Records, VAH, Fort Howard, Maryland</b>                                                                                            |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4123</b> IMMEDIATE CAUSE (a) <b>CHRONIC CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>CONDITIONS, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) |  |  |                         |  |                                                                                                                            |                                     |  |  |  |                                                                                                                                                             |                                                      |  |  |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>MONTHS</b><br><b>YEARS</b>     |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                           |                                     |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                      |  |  |                                | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                          |                                     |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                            |                                     |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>January 2, 1969</b> , to <b>February 23, 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>Feb. 23, 1969</b> , and that in my (our) opinion death occurred on the date and hour and from the<br>causes stated above <del>XX</del> (we) (did) (did not) view the body after death.                                                                                                                                                                                        |  |  |                         |  |                                                                                                                            |                                     |  |  |  |                                                                                                                                                             |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>V. Chitraplee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |                         |  |                                                                                                                            |                                     |  |  |  | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                |                                                      |  |  |                                | 22c. DATE SIGNED<br><b>2/23/69</b>                                                   |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>VADHANA CHITRAPLEE, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                         |  |                                                                                                                            |                                     |  |  |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>                                                                                                   |                                                      |  |  |                                |                                                                                      |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                         |  | 23b. DATE<br><b>Feb. 26, 1969</b>                                                                                          |                                     |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National Cemetery</b>                                                                                       |                                                      |  |  |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |  |                                |  |  |                                                       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns &amp; Sons</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |                         |  |                                                                                                                            |                                     |  |  |  | ADDRESS<br><b>York Road<br/>Towson, Maryland</b>                                                                                                            |                                                      |  |  |                                | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 3 1969</b>                                    |  |                                |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Gudge</b> |  |  |  |  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                           |                                                                                                                   |                                                                                                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                           |                                                                                                                   |                                                                                                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                           |                                                                                                                   |                                                                                                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 1. DECEASED-NAME (Type or print)<br><b>EDNA REGINA KRANTZ GETTIER</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                           |                                                                                                                   |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>28th</b> Year <b>1969</b>                                                            |                                                                                                             |                                                                                                 | 2b. HOUR<br><b>P.M.</b>                              |                                                                 |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>WHITE</b>                                                                   |                                                                                                                   | 5. DATE OF BIRTH<br><b>11-6-1887</b>                                                                                                                        |                                                                                                                                        | 6. AGE (In years last birthday)<br><b>81</b> YRS.                                                           |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>     |                                                                 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                             |                                                                                                                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                                                  |                                                                                                 |                                                      |                                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>LUTHERVILLE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>COLLEGE MANOR NURSING HOME</b> |                                                                                                                                                             |                                                                                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b> |                                                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>BALTO., MD.</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                           | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                  |                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                      | 13e. STREET AND NUMBER<br><b>HOPKINS APTS. 3100 ST. PAUL ST</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>G. FRED KRANZ</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                           |                                                                                                                   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>REGINA ELIZABETH FRANCE</b>                                                                                |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>214-46-7988</b>                                                                    |                                                                                                                                                             | 17. INFORMANT Address<br><b>Mrs. Elisha R. Jones, 106 Hawthorne Rd., Balto.,</b>                                                       |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4124</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 + yrs</b> |  |                                                                                           |                                                                                                                   |                                                                                                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                          |  |                                                                                           |                                                                                                                   |                                                                                                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                          |                                                                                                                   |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                   |                                                                                                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                                      |                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____ |                                                                                                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)              |                                                                                                                   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                                                                        |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/22/69</b> , 19____, to <b>2/28/69</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/27/69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                      |  |                                                                                           |                                                                                                                   |                                                                                                                                                             |                                                                                                                                        |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 22b. SIGNATURE<br><b>Francis W. Gluck</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                           |                                                                                                                   |                                                                                                                                                             | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                                             | 22c. DATE SIGNED<br><b>2/28/69</b>                                                              |                                                      |                                                                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Francis W. Gluck</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                           |                                                                                                                   |                                                                                                                                                             | 22e. ADDRESS<br><b>100 W. University Pkwy., Balto.</b>                                                                                 |                                                                                                             |                                                                                                 |                                                      |                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>3/3/1969</b>                                                              |                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                                                                                                    |                                                                                                                                        | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                                       |                                                                                                 |                                                      |                                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                           |                                                                                                                   |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 4 1969</b>                                                                                      |                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                              |                                                      |                                                                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 1. DECEASED-NAME<br>(Type or print) <b>MARY</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | First <b>ELIZABETH</b>                                                                                                                 |  |  | Middle <b>GLASCOCK</b>                                                                                                                                      |  |  | Last                                                                                         |                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 4. RACE<br><b>White</b>                                                                                                                |  |  | 5. DATE OF BIRTH<br><b>9-28-17</b>                                                                                                                          |  |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>15</b> Year <b>1969</b>                    |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                       |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b>                           |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                             |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                  |  |  | 13b. COUNTY<br><b>Carroll</b>                                                                                                          |  |  | 13c. CITY OR TOWN<br><b>Sykesville</b>                                                                                                                      |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              |  |
| 14. FATHER'S NAME First <b>John</b> Middle <b>M.</b> Last <b>deLashmutt</b>                                                                                                                                                                                                                                                                                                                                                                       |  |  | 15. MOTHER'S MAIDEN NAME First <b>Helen</b> Middle <b>Matthews</b> Last                                                                |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>                                        |  |  | 16b. SOCIAL SECURITY NO.<br><b>?</b>                                                         |                                              |  |
| 17. INFORMANT<br><b>Hospital Records</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | Address                                                                                                                                |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>150 X</b><br>Contributory to: <b>1) Purulent tracheal bronchitis</b><br><b>2) Carcinoma of the esophagus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                             |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                              |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                          |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                              |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> , 19 <b>69</b> , to <b>Feb. 15</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb. 15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                                                                         |  |  |                                                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 22b. SIGNATURE<br><b>Cilliani</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>2-15-1969</b>                                                                                                                        |  |  |                                                                                              |                                              |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |  | 22e. ADDRESS<br><b>7620 York Road, Towson 4, Maryland</b>                                                                              |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 23b. DATE<br><b>2-17-69</b>                                                                                                            |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                                                                                            |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Frederick Md.</b>                        |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | ADDRESS<br><b>Sykesville, Md.</b>                                                                                                      |  |  | 25a. REC'D BY REGISTRAR<br><b>EEF 19 1969</b>                                                                                                               |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                             |                                              |  |

10000

10000

10000

10000

10000

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                         |  |                                                                              | First Middle Last                                                            |                                                                                                                                                             |                                                                                   | 2a. DATE OF DEATH                                                                       |                                                                                                                                 |                                   | 2b. HOUR                                                      |
| RITA                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | COONIN                                                                       |                                                                                                                                                             |                                                                                   | GLUSHAKOW                                                                               |                                                                                                                                 |                                   | FEBRUARY Month 12, Day 1969 Year 10 P M                       |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                            |                                                                                   |                                                                                         | 6. AGE (In years last birthday)                                                                                                 |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS                                |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                      |  | WHITE                                                                        |                                                                              | JULY 25, 1900                                                                                                                                               |                                                                                   |                                                                                         | 68 YRS.                                                                                                                         |                                   | IF UNDER 24 HRS.<br>HOURS MIN                                 |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                      |                                                                                                                                 |                                   |                                                               |
| LATVIA                                                                                                                                                                                                                                                                                                                                                                      |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                             |                                                                                   | BALTIMORE Md.                                                                           |                                                                                                                                 |                                   |                                                               |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                             |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |                                                               |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              | MILFORD MANOR NURSING HOME                                                   |                                                                                                                                                             |                                                                                   | HOUSEWIFE                                                                               |                                                                                                                                 | AT HOME                           |                                                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                               |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN                                                                 |                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                               |                                   | 13e. STREET AND NUMBER                                        |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                                                                              |                                                                                                                                                             | BALTIMORE                                                                         |                                                                                         |                                                                                                                                 |                                   | 4002 GLENGYLE AVENUE                                          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              | First Middle Last                                                            |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| YUDEL                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | CAWN                                                                         |                                                                                                                                                             |                                                                                   | BRINA ?                                                                                 |                                                                                                                                 |                                   |                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                                                                            |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                             | 17. INFORMANT Address                                                             |                                                                                         |                                                                                                                                 |                                   |                                                               |
| NO                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                             | MR. A. D. GLUSHAKOW, 4002 GLENGYLE AVE. #15                                       |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1950 Abdominal carcinoma, large, site of origin unknown<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year approx |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>0                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                            |                                   |                                                               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 1969                 |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION (Street or R.F.D. No. City or Town County State)                                                                                              |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-10, 1969, to 2-12, 1969, that (I) (we) lost saw the deceased alive on 2-10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                             |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 22b. SIGNATURE<br>H. Gerald Oster MD                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                             | DEGREE                                                                            |                                                                                         | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br>2/13/69                                   |
| 22d. PHYSICIAN'S NAME (Type)<br>H. GERALD OSTER                                                                                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                             | 22e. ADDRESS<br>6821 REISTERSTOWN ROAD                                            |                                                                                         |                                                                                                                                 |                                   |                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                   |                                                                                         | 23d. LOCATION (City or Town) (County) (State)                                                                                   |                                   |                                                               |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                      |  | 2-14-69                                                                      |                                                                              | SHAAREI ZION                                                                                                                                                |                                                                                   |                                                                                         | ROSEDALE, MARYLAND                                                                                                              |                                   |                                                               |
| 24. FUNERAL DIRECTOR ADDRESS<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                              |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br>DATE FEB 17 1969                                       |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                                                                                      |                                   |                                                               |

32032

32032

20

ELIZABETH A. BROWN

COOPER

STAN

JULY 22, 1923

WHITE

WHITE

BALTIMORE

M.D.A.

LATINA

AT HOME

ALFRED W. BROWN

BALTIMORE

4001 ELM ST. APT. 2

ESTIMATE

RECEIVED

BROWN

CANON

UNIT

MRS. A. B. BROWN, 4001 ELM ST. APT. 2

4001 ELM ST. APT. 2

STRAID & CO.

BALTIMORE, MARYLAND

CHARGEI ALON

2-1-22

UNITAL

4001 ELM ST. APT. 2, BALTIMORE, MARYLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------|--|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                       |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                               |  | First                                                                        |  | Middle                                                                                                                                                      |  | Last                                                                              |  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR                                     |
| IRENE                                                                                                                                                                                                                                                                                                                                                                                             |  | E.                                                                           |  | GOLDEN                                                                                                                                                      |  | FEBRUARY                                                                          |  | 4, 1969                             |  | 7:00 AM                                      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                            |  | 6. AGE (In years last birthday)                                                   |  | IF UNDER 1 YEAR                     |  | IF UNDER 24 HRS.                             |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                                            |  | WHITE                                                                        |  | MARCH 12, 1924                                                                                                                                              |  | 44 YRS.                                                                           |  | MONTHS DAYS                         |  | HOURS MIN.                                   |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                                |  | Md.                                 |  |                                              |
| ENGLAND                                                                                                                                                                                                                                                                                                                                                                                           |  | U.K.                                                                         |  |                                                                                                                                                             |  | BALTIMORE                                                                         |  |                                     |  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |  |                                     |  |                                              |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                                            |  | ST. JOSEPH HOSPITAL                                                          |  | HOMEMAKER                                                                                                                                                   |  |                                                                                   |  |                                     |  |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER              |  |                                              |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                          |  | BALTIMORE                                                                    |  | DUNDALK                                                                                                                                                     |  |                                                                                   |  | 2815 KIRKLEIGH RD. #21222           |  |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                 |  | First                                                                        |  | Middle                                                                                                                                                      |  | Last                                                                              |  | 15. MOTHER'S MAIDEN NAME            |  |                                              |
| WALTER P. PERKINS                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  | EDITH E. MANLEY                     |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                  |  | (If yes give war or dates of service)                                        |  | 16b. SOCIAL SECURITY NO.                                                                                                                                    |  | 17. INFORMANT                                                                     |  | Address                             |  |                                              |
| NO                                                                                                                                                                                                                                                                                                                                                                                                |  | ####                                                                         |  | 220/48/8336                                                                                                                                                 |  | JOHN I. GOLDEN                                                                    |  | AS IN # 13                          |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding</u>                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| 150X DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| (b) <u>gastric peptic ulcer</u>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| (c)                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| <u>Carcinoma of esophagus with extensive metastasis; Bronchopneumonia.</u>                                                                                                                                                                                                                                                                                                                        |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?                                                                                                                                               |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |                                     |  |                                              |
| 1/14/69                                                                                                                                                                                                                                                                                                                                                                                           |  | Ca. of esophagus                                                             |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                         |  |                                                                                   |  |                                     |  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                   |  |                                     |  |                                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                   |  |                                     |  |                                              |
| 22a. I certify that <del>it</del> (this hospital) attended the deceased from <u>January 11, 1969</u> , to <u>February 4, 1969</u> , that <del>it</del> (we) lost saw the deceased alive on <u>February 4, 1969</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death. |  |                                                                              |  |                                                                                                                                                             |  |                                                                                   |  |                                     |  |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                    |  | 22c. DATE SIGNED                                                             |  | 22d. ADDRESS                                                                                                                                                |  | 22e. ADDRESS                                                                      |  |                                     |  |                                              |
| Ines Cilliari, M.D.                                                                                                                                                                                                                                                                                                                                                                               |  | 2-4-69                                                                       |  | 7620 York Road, Towson, Md. 21204                                                                                                                           |  |                                                                                   |  |                                     |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |                                     |  |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                            |  | 2/6/69                                                                       |  | OAK LAWN                                                                                                                                                    |  | BALTO. CO., MD.                                                                   |  |                                     |  |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                              |  | 25a. REC'D BY REGISTRAR                                                      |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |  |                                                                                   |  |                                     |  |                                              |
| W. BROOKS BRADLEY, DUNDALK, MD.                                                                                                                                                                                                                                                                                                                                                                   |  | DATE FEB 7 1969                                                              |  | Charles Judge                                                                                                                                               |  |                                                                                   |  |                                     |  |                                              |

00000

00000

00000

00000

00000 / 00000

00000

2/1

02012

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | First<br><b>John</b>                                                                                            |  | Middle<br><b>H.</b>                                                                                                                                         |  | Last<br><b>Gooch</b>                                                                            |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>13</b> Year <b>1969</b>   |  |                                    |  | 2b. HOUR<br><b>2:55</b> P.M.                 |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br><b>white</b>                                                                                         |  | 5. DATE OF BIRTH<br><b>Dec. 22, 1888</b>                                                                                                                    |  |                                                                                                 |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS     |  | IF UNDER 24 HRS.<br>HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Colorado</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                                                    |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |  |                                                                             |  |                                    |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>L.N.R.R. agent</b>                                            |  |                                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                           |  |                                    |  |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY<br><b>Pr. Geo.</b>                                                                                  |  | 13c. CITY OR TOWN<br><b>Lanham</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>9230 Fowler Lane</b>                           |  |                                    |  |                                              |  |
| 14. FATHER'S NAME First Middle Last<br><b>George Richard Gooch</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Sarah Elizabeth HITE</b>                                                                                   |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>                                                                      |  | 17. INFORMANT <b>MRS OLIVE D. GOOCH</b> Address <b>SAME AS #13</b><br><b>Records: SPRING GROVE STATE HOSPITAL</b>                                           |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Peritonitis due to large bowel perforation, severe dehydration and uremia.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCD (aortic dissection)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCD (aortic dissection)</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>disease - Pneumonitis, acute.</b> |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                             |  |                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |                                    |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 5, 1969</b> , to <b>Feb. 13, 1969</b> , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 13, 1969</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.                                                              |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
| 22b. SIGNATURE<br><b>Rafael H. Marin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | DEGREE                                                                                                          |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>                                                                                                      |  | MED. DIRECTOR <input type="checkbox"/>                                                          |  | STAFF PHYS.<br><input type="checkbox"/>                                     |  | 22c. DATE SIGNED<br><b>2-13-69</b> |  |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Rafael H. Marin, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>                                |  |                                                                                                                                                             |  |                                                                                                 |  |                                                                             |  |                                    |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>2-18-1969</b>                                                                                   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FRANKFORT CEMETERY</b>                                                                                             |  |                                                                                                 |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FRANKFORT, KENTUCKY</b> |  |                                    |  |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>W.W. CHAMBERS CO.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | ADDRESS<br><b>RIVERDALE, MARYLAND</b>                                                                           |  | 25a. REC'D BY REGISTRAR<br><b>DATE FEB 20 1969</b>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                              |  |                                                                             |  |                                    |  |                                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03007

MINUTE OF DEED

02007



*[Faint, mostly illegible text and markings on a document form, possibly a deed or minute. Some visible fragments include:]*

*[Faint text at top:]* ...  
*[Faint text in middle:]* ...  
*[Faint text at bottom:]* ...

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 02013 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    | 02008                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--------------------|----------------------------------------------|--|
| Item #5, Film G409 2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| 1. DECEASED-NAME (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | First Middle Last            |                                                                              |  | 20. DATE KNOWN OF ESTI-DEATH MATED                                                                        |  |                                                                                         | 2b. HOUR           |                                              |  |
| Cruz Martin Gotschall                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              |                              |                                                                              |  | Month Day Year                                                                                            |  |                                                                                         | M                  |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                                                                      |                              | 5. DATE OF BIRTH                                                             |  | 6. AGE (In years last birthday)                                                                           |  | 7c. DATE PRONOUNCED DEAD                                                                |                    | 2d. HOUR                                     |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | White                                                                        |                              | August 7, 1924                                                               |  | 45 YRS.                                                                                                   |  | Month Day Year                                                                          |                    | M                                            |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              |  | 8. MARRIED                                                                                                |  |                                                                                         | 9. COUNTY OF DEATH |                                              |  |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              | USA                          |                                                                              |  | WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                         | BALTO, Md.         |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                                                                                           |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                    | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| CATONSVILLE                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |                              | MARYLAND AVE                                                                 |  |                                                                                                           |  | STEEL WORKER                                                                            |                    |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                              | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                         |  | 13d. INSIDE CITY LIMITS?                                                                |                    | 13e. STREET AND NUMBER                       |  |
| Md                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                              | BALTO                                                                        |  | CATONSVILLE                                                                                               |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |                    | 508 MARYLAND AVE                             |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              | 15. MOTHER'S MAIDEN NAME     |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              | First Middle Last            |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| Glenn Gotschall                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | Margaret Shelly              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              | 16b. SOCIAL SECURITY NO.     |                                                                              |  | 17. INFORMANT                                                                                             |  |                                                                                         | ADDRESS            |                                              |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | 216-12-0878                  |                                                                              |  | Dorothy C. Gotschall                                                                                      |  |                                                                                         | 508 MARYLAND AVE   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to Carbon Monoxide                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| 9520 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                    |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                                                                                                           |  | 20. AUTOPSY?                                                                            |                    |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                              |                                                                              |  |                                                                                                           |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                    |                                              |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                              |                              | 21b. TIME OF INJURY Month, Day, Year                                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |  |                                                                                         |                    |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                              | HOUR A.M. P.M.                                                               |  | Exhaust Fumes into Car                                                                                    |  |                                                                                         |                    |                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                 |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Street                                                                       |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                              |                              |                                                                              |  |                                                                                                           |  |                                                                                         |                    |                                              |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                              |                                                                              |  | CHIEF MEDICAL EXAMINER                                                                                    |  |                                                                                         | 22b. DATE SIGNED   |                                              |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                              |                                                                              |  | DEPUTY MEDICAL EXAMINER                                                                                   |  |                                                                                         |                    |                                              |  |
| RONALD N. KORNBLUM M.D.                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                              |                                                                              |  | ADDRESS (Street, city, town, or county)                                                                   |  |                                                                                         |                    |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE                                                                    |                              | 23c. NAME OF CEMETERY OR CREMATORY                                           |  | 23d. LOCATION (City or Town) (County) (State)                                                             |  |                                                                                         |                    |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2/10/69                                                                      |                              | BALTIMORE NATIONAL CEM                                                       |  | BALTO, Md                                                                                                 |  |                                                                                         |                    |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                              |                                                                              |  | 25a. REC'D BY REGISTRAR                                                                                   |  | 25b. REGISTRAR'S SIGNATURE                                                              |                    |                                              |  |
| E.S. MacNabb 301 Frederick Rd Balto Md                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                              |                                                                              |  | FEB 10 1969                                                                                               |  |                                                                                         |                    |                                              |  |



03008

03013

1000-1000





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                            |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------|--|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|----------------------------------------------------------------------------------------------|------------|--|----------------------------------------------|--|------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                    |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                           |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                               |  |  | First                                                                        |  | Middle |                                                                                                                                                          | Last  |  | 2a. DATE OF DEATH                                                                            |            |  | 2b. HOUR                                     |  |                  |  |  |
| CHARLES                                                                                                                                                                                                                                                                                                        |  |  | E                                                                            |  | GRAIL  |                                                                                                                                                          | Feb 4 |  |                                                                                              | Month 1969 |  | Year 6 A M                                   |  |                  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                         |  |  | 4. RACE                                                                      |  |        | 5. DATE OF BIRTH                                                                                                                                         |       |  | 6. AGE (In years last birthday)                                                              |            |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS. |  |  |
| Male                                                                                                                                                                                                                                                                                                           |  |  | White                                                                        |  |        | June 13, 1894                                                                                                                                            |       |  | 74                                                                                           |            |  | MONTHS                                       |  | DAYS             |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |       |  | 9. COUNTY OF DEATH                                                                           |            |  |                                              |  |                  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                       |  |  | U.S.A.                                                                       |  |        |                                                                                                                                                          |       |  | Baltimore                                                                                    |            |  |                                              |  | Md.              |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                      |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |            |  |                                              |  |                  |  |  |
| Towson                                                                                                                                                                                                                                                                                                         |  |  | 415 Hopkins Rd.                                                              |  |        | Retired Cab Business                                                                                                                                     |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                  |  |  | 13b. COUNTY                                                                  |  |        | 13c. CITY OR TOWN                                                                                                                                        |       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            |  | 13e. STREET AND NUMBER                       |  |                  |  |  |
| Md.                                                                                                                                                                                                                                                                                                            |  |  | Balto.                                                                       |  |        | Towson                                                                                                                                                   |       |  | YES                                                                                          |            |  | 415 Hopkins Rd.                              |  |                  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                              |  |  | 15. MOTHER'S MAIDEN NAME                                                     |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| First Middle Last                                                                                                                                                                                                                                                                                              |  |  | First Middle Last                                                            |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| Thomas P Grail                                                                                                                                                                                                                                                                                                 |  |  | Mary Mitchell                                                                |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)                                                                                                                                                                                                                             |  |  | 16b. SOCIAL SECURITY NO.                                                     |  |        | 17. INFORMANT                                                                                                                                            |       |  | Address                                                                                      |            |  |                                              |  |                  |  |  |
| Yes No, or unknown                                                                                                                                                                                                                                                                                             |  |  | WW1                                                                          |  |        | 216-01-2839                                                                                                                                              |       |  | Mrs Anna C Grail                                                                             |            |  | Same                                         |  |                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                      |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |  |
| PART 1. DEATH CAUSED BY:                                                                                                                                                                                                                                                                                       |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis                                                                                                                                                                                                                                                                   |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  | Ser. hrs.                                    |  |                  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular                                                                                                                                                                                                                                             |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  | Many                                         |  |                  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) dis.                                                                                                                                                                                                        |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  | years                                        |  |                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                             |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| Viral pneumonitis                                                                                                                                                                                                                                                                                              |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |            |  |                                              |  |                  |  |  |
|                                                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                             |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
|                                                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                       |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
|                                                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/23, 1968, to 1/8, 1969, that (I) (we) last saw the deceased alive on 1-9-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                                                              |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                 |  |  | 22c. DATE SIGNED                                                             |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| Wm J. Vitale M.D.                                                                                                                                                                                                                                                                                              |  |  | 2-4-69                                                                       |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                   |  |  | 22e. ADDRESS                                                                 |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| William J Vitale M.D.                                                                                                                                                                                                                                                                                          |  |  | 6800 Loch Raven Blvd. BaltoMd                                                |  |        |                                                                                                                                                          |       |  |                                                                                              |            |  |                                              |  |                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                      |  |  | 23b. DATE                                                                    |  |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |       |  | 23d. LOCATION (City or Town) (County) (State)                                                |            |  |                                              |  |                  |  |  |
| Burial                                                                                                                                                                                                                                                                                                         |  |  | 2/7/69                                                                       |  |        | Dulaney Valley                                                                                                                                           |       |  | Baltimore, Maryland                                                                          |            |  |                                              |  |                  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                           |  |  | ADDRESS                                                                      |  |        | 25a. REC'D BY REGISTRAR                                                                                                                                  |       |  | 25b. REGISTRAR'S SIGNATURE                                                                   |            |  |                                              |  |                  |  |  |
| Leonard J. Ruck Inc. Balto. Md. 21214                                                                                                                                                                                                                                                                          |  |  |                                                                              |  |        | FEB 5 1969                                                                                                                                               |       |  | Charles Judge                                                                                |            |  |                                              |  |                  |  |  |

11  
...  
...

...  
...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02010

02015

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                          |  |  | First Middle Last                                                                                      |  |  | 2a. DATE OF DEATH<br>Month Day Year                                                                                                                         |  |  | 2b. HOUR<br>3:07 PM                                                                             |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                             |  |  | 4. RACE<br>White                                                                                       |  |  | 5. DATE OF BIRTH<br>February 6, 1969                                                                                                                        |  |  | 6. AGE (In years<br>lost birthday)                                                              |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland                                                                                                                                                                                                                                                                                                                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                 |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore, Md.                                                            |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                          |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>N/A                                                           |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland                                                                                                                                                                                                                                                                 |  |  | 13b. COUNTY<br>Baltimore                                                                               |  |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br>1405 Taylor Ave.                                                                                                                                                                                                                                                                                                                                   |  |  | 14. FATHER'S NAME<br>First Middle Last<br>James W Hancock                                              |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth A Swanson                                                                                        |  |  |                                                                                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)                                                                                                                                                                                                                                                                                                        |  |  | 16b. SOCIAL SECURITY NO.                                                                               |  |  | 17. INFORMANT                                                                                                                                               |  |  | Address                                                                                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hyaline membrane disease</u><br><u>7761</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                           |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                       |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                     |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                             |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                               |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <u>2/6/</u> , 19 <u>69</u> , to <u>2/7/</u> , 19 <u>69</u> , that (A) (we) last<br>saw the deceased alive on <u>2/7/</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |
| 22b. SIGNATURE<br><u>Lucilia M.D.</u>                                                                                                                                                                                                                                                                                                                                        |  |  | DEGREE                                                                                                 |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br>2/7/69                                                                      |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>INES CILLIANI M.D.                                                                                                                                                                                                                                                                                                                        |  |  | 22e. ADDRESS<br>7620 York Rd, Towson, Md. 21204                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |
| 23a. BURIAL (CREMATION)<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                 |  |  | 23b. DATE<br>2.12.69                                                                                   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>V. of Md. Med. School                                                                                                 |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md.                                  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                         |  |  | ADDRESS                                                                                                |  |  | 25a. REC'D BY REGISTRAR<br>FEB 14 1969                                                                                                                      |  |  | 25b. REGISTRAR'S SIGNATURE                                                                      |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02016

02011

|                                                                                                                                                                                                                                                                                                                                                                                    |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MYRTLE R. HANDS</b>                                                                                                                                                                                                                                                                                                                         |  |                                            | First Middle Last                                                                                        |                                                                                                                                                             |                                                                    | 2a. DATE OF DEATH<br>Month Day Year<br><b>February 1, 1969</b>                                                 |                                                                                                 |                                                                             | 2b. HOUR<br>M                                                           |  |                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>White</b>                    |                                                                                                          | 5. DATE OF BIRTH<br><b>June 23, 1891</b>                                                                                                                    |                                                                    |                                                                                                                | 6. AGE (In years<br>lost birthday)<br><b>77</b> YRS.                                            |                                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS                                          |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Penna.</b>                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |                                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                    |                                                                                                                | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |                                                                             |                                                                         |  |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Middle River 21220</b>                                                                                                                                                                                                                                                                                                                             |  |                                            | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>19 W. Midland Rd.</b> |                                                                                                                                                             |                                                                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b> |                                                                                                 |                                                                             | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Home</b>                     |  |                                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                   |  |                                            | 13b. COUNTY<br><b>Baltimore</b>                                                                          |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Middle River</b>                           |                                                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                             | 13e. STREET AND NUMBER<br><b>19 W. Midland Road</b>                     |  |                                                 |  |
| 14. FATHER'S NAME First Middle Last<br><b>Charles Renier</b>                                                                                                                                                                                                                                                                                                                       |  |                                            | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary E. Meyers</b>                                      |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service) <b>--</b>                                                                                                                                                                                                                                                    |  |                                            | 16b. SOCIAL SECURITY NO.<br><b>217 01 7493A</b>                                                          |                                                                                                                                                             | 17. INFORMANT<br><b>Earl Hands</b> Address <b>Same</b>             |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>561X Dehydration</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>acute enteritis</b> |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>pericarditis</b>                                                                                                                                                                                                                         |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                         |                                                                                                                                                             |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |                                                                                                 |                                                                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                           |  |                                            | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                        |                                                                                                                                                             |                                                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                       |  |                                            | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |                                                                                                                                                             |                                                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                   |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1968</b> to <b>2-1, 1969</b> , that (I) (we) last saw the deceased alive on <b>2-1, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  |                                                 |  |
| 22b. SIGNATURE<br><b>Marvin J. Rombro</b> M.D. DEGREE                                                                                                                                                                                                                                                                                                                              |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  | 22c. DATE SIGNED<br><b>2-3 69</b>               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Marvin J. Rombro, M.D.</b>                                                                                                                                                                                                                                                                                                                      |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    |                                                                                                                |                                                                                                 |                                                                             |                                                                         |  | 22e. ADDRESS<br><b>805 Fuselage Avenue</b>      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                            | 23b. DATE<br><b>2/4/69</b>                                                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Crematory</b> |                                                                                                                |                                                                                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |                                                                         |  |                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>James E. Bruzdinski</b> ADDRESS<br><b>1407 Eastern Ave. 21221</b>                                                                                                                                                                                                                                                                                       |  |                                            |                                                                                                          |                                                                                                                                                             |                                                                    | 25a. RECEIVED BY REGISTRAR<br>DATE <b>FEB 4 1969</b>                                                           |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                            |                                                                         |  |                                                 |  |

02011

GEORGE OF DEATH

02011

February 1, 1952

MINI. 1. 1952

June 27, 1951

White

White

White

USA

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White

White



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTO. MD. 21201                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                                                    |                                                                                                                                                             |                                                                                                                                           |                                                                                                              |                                                                      |                                                                  |                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Evelyn A. Hanna</b>                                                                                                                                                                                                                                                                                                   |  |                                                                              |                                                                                                    |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month Day Year<br><b>Feb. 12, 1969</b>                                                                               |                                                                                                              |                                                                      | 2b. HOUR<br>10:30 M                                              |                                                                |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>White</b>                                                      |                                                                                                    | 5. DATE OF BIRTH<br><b>Nov. 28, 1887</b>                                                                                                                    |                                                                                                                                           | 6. AGE (In years last birthday)<br><b>81</b> YRS.                                                            |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                                                                |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |                                                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                           | 9. COUNTY OF DEATH<br><b>Balto. Catonsville</b> Md.                                                          |                                                                      |                                                                  |                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summit Home</b> |                                                                                                                                                             |                                                                                                                                           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House Wife</b> |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                |                                                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Balto.</b>                                                 |                                                                                                    | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |                                                                      | 13e. STREET AND NUMBER<br><b>4421 Allan Drive</b>                |                                                                |
| 14. FATHER'S NAME First Middle Last<br><b>Henry Taylor</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                                                    | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Roberta Gray</b>                                                                                           |                                                                                                                                           |                                                                                                              |                                                                      |                                                                  |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                           |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                                           |                                                                                                                                                             | 17. INFORMANT Address<br><b>Mr. Charles J. Hanna 4421 Allan Drive</b>                                                                     |                                                                                                              |                                                                      |                                                                  |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC C.V. Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                              |                                                                                                    |                                                                                                                                                             |                                                                                                                                           |                                                                                                              |                                                                      |                                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS +</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ARTERIOSCLEROTIC GANGRENE OF LEG</b>                                                                                                                                                                                                     |  |                                                                              |                                                                                                    |                                                                                                                                                             |                                                                                                                                           |                                                                                                              |                                                                      |                                                                  |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                    |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                                              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                  |                                                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                    |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                           |                                                                                                              |                                                                      |                                                                  |                                                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                    |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No.                                                                                                        |                                                                                                              | City or Town                                                         |                                                                  | County State                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1955, to <b>2/12, 1969</b> , that (I) (we) lost saw the deceased alive on <b>2/11</b> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                    |  |                                                                              |                                                                                                    |                                                                                                                                                             |                                                                                                                                           |                                                                                                              |                                                                      |                                                                  |                                                                |
| 22b. SIGNATURE<br><b>Thos E. Roach MD</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                                                    |                                                                                                                                                             | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                                              | 22c. DATE SIGNED<br><b>2/14/69</b>                                   |                                                                  |                                                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>5550 Balto Nat Pike</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                                                    |                                                                                                                                                             | 22e. ADDRESS<br><b>Thos E Roach MD</b>                                                                                                    |                                                                                                              |                                                                      |                                                                  |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>Feb. 15, 1969</b>                                            |                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>                                                                                               |                                                                                                                                           |                                                                                                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>   |                                                                  |                                                                |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                                                                                                    |                                                                                                                                                             | 5151 Balto. Nat. Pike ADDRESS<br><b>Balto. Md.</b>                                                                                        |                                                                                                              | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 18 1969</b>                |                                                                  | 25b. REGISTRAR'S SIGNATURE                                     |

.. House of Representatives  
511 House, Wash. D.C.  
Feb. 12, 1909  
Hon. J. H. ...

Mr. Charles J. ...

1211 ...

House ...

1211 ...

Nov. 20, 1907

1211 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4  
45M - 1

| 02018                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 | 02013                                                                                |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|--|-------------------------------------------------------------------------|--|--|--|--|--------------------------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 | CERTIFICATE OF DEATH                                                                 |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>ADELE</b> <b>(Elizabeth A. Harker)</b> <b>HARKER</b>                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                            |  | 2a. DATE OF DEATH<br><b>FEBRUARY</b> <b>4</b> , Day <b>1969</b>                 |                                                                                                                                                             |  |  |                                                                                                 | 2b. HOUR<br><b>10:30</b> <b>P</b>                                                    |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 4. RACE<br><b>WHITE</b>                                                                                    |  |                                                                                 | 5. DATE OF BIRTH<br><b>September 18, 1883</b>                                                                                                               |  |  | 6. AGE (In years<br>lost birthday) <b>85</b> YRS.                                               |                                                                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS                              |  |  | IF UNDER 24 HRS.<br>HOURS MIN                                           |  |  |  |  |                                                  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |  |                                                                                 | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.                                                     |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 1d. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>ST. JOSEPH HOSPITAL</b> |  |                                                                                 | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired) <b>Part-Time Work</b>                                             |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY <b>Emerson Hotel</b>                                       |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                         |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                            |  |                                                                                 | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                      |  | 13e. STREET AND NUMBER<br><b>1410 MT. ROYAL AVE. #21217</b> |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Jessie Hitchcock</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                            |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Rebecca Stover</b>             |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-3808</b>                                  |                                                                                                                                                             |  |  |                                                                                                 | 17. INFORMANT Address<br><b>Mrs. Ada H. Muller, 424 Homeland Ave.</b>                |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b><br><b>4319</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                                       |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                                                                                                                                                             |  |  |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                             |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |  |  |  |                                                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                                                                                                                                                             |  |  |                                                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                           |  |  |                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                                                                                                                                                             |  |  |                                                                                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>FEBRUARY 3</b> , 19 <b>69</b> , to <b>FEBRUARY 4</b> 19 <b>69</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>February 4</b> , 19 <b>69</b> , and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) <b>(not)</b> view the body after death.                                         |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 22b. SIGNATURE<br><b>Gualberto Gokim, Jr., M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED<br><b>February 4, 1969</b>                                                                                                                                                                                                                   |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GUALBERTO GOKIM, JR., M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                            |  | 22e. ADDRESS<br><b>7620 YORK ROAD TOWSON, MARYLAND #21204</b>                   |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  |                                                                         |  |  |  |  |                                                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |  |                                                                                                            |  | 23b. DATE<br><b>2/7/1969</b>                                                    |                                                                                                                                                             |  |  |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ayres Chapel</b>                            |  |                                                             |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>White Hall, Md.</b> |  |  |  |  |                                                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b> ADDRESS                                                                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                            |  |                                                                                 |                                                                                                                                                             |  |  |                                                                                                 |                                                                                      |  |                                                             |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 7 1969</b> DATE                       |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |  |  |

51080

51080

SEARCHED INDEXED  
SERIALIZED FILED  
JUN 1964  
FBI - NEW YORK

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02019

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02014

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                            |                                                                                                                    |                                                                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>JAMES BERNARD HARRIS</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                            | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>Feb. 3 19 69</b> |                                                                                                                                                             |                                                                                                          | 2b. HOUR <b>12:40</b>                                                                                      |                                                                                                |                                                                                                    |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>7/6/98</b>                                                                             | 6. AGE (In years last birthday) <b>70</b> YRS.                                                                     | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                            | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                                         | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb.</b> Day <b>3</b> Year <b>19 69</b>                               |                                                                                                |                                                                                                    |  |
| 7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.A.S.</b>                                                                 |                                                                                                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                          | 9. COUNTY OF DEATH <b>Baltimore</b>                                                                        |                                                                                                |                                                                                                    |  |
| 10. CITY OR TOWN OF DEATH <b>Fort Howard</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Veterans Adm. Hospital</b> |                                                                                                                    |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b> |                                                                                                            | 12b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>                                         |                                                                                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                   |                      | 13b. COUNTY <b>A. Arundel</b>                                                                              |                                                                                                                    | 13c. CITY OR TOWN <b>Pasadena</b>                                                                                                                           |                                                                                                          | 13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |                                                                                                | 13e. STREET AND NUMBER <b>503-209th Street</b>                                                     |  |
| 14. FATHER'S NAME <b>NELSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      |                                                                                                            | 15. MOTHER'S MAIDEN NAME <b>HARRIS VIRGINIA RIFFLE</b>                                                             |                                                                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                                                            | 16b. SOCIAL SECURITY NO. <b>236 01 97 49</b>                                                                       |                                                                                                                                                             | 17. INFORMANT <b>Eleanor Stumpf (daughter) Glen Burnie</b>                                               |                                                                                                            |                                                                                                |                                                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONITIS, BILATERAL</b><br><b>887X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>FRACTURE LEFT HIP</b>                                                              |                      |                                                                                                            |                                                                                                                    |                                                                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 DAYS</b><br><b>18 DAYS</b><br><b>41 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                                                                             |                      |                                                                                                            |                                                                                                                    |                                                                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                  |                                                                                                                                                             |                                                                                                          |                                                                                                            | 20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |                                                                                                    |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                     |                      | 21b. TIME OF INJURY Month, Day, Year <b>12-24-68</b> HOUR A.M. <b>12</b> P.M. <b>12</b>                    |                                                                                                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <b>Fell at Home</b>                                                         |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                               |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>                   |                                                                                                                    | 21f. LOCATION Street or R.F.D. No. <b>503-209th St - Pasadena - AA - Md</b> City or Town <b>Pasadena</b> County <b>AA</b> State <b>Md</b>                   |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                      |                                                                                                            |                                                                                                                    |                                                                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
| ACTUAL SIGNATURE <b>M B Davis</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                            |                                                                                                                    |                                                                                                                                                             |                                                                                                          | 22b. DATE SIGNED <b>2/3/69</b>                                                                             |                                                                                                |                                                                                                    |  |
| EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M. D., 6800 MORNINGSIDE RD. BALTIMORE, MD. 21222</b>                                                                                                                                                                                                                                                                                                                                                                 |                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                |                                                                                                                    |                                                                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                      | 23b. DATE <b>Feb. 6, 1969</b>                                                                              |                                                                                                                    | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>                                                                                           |                                                                                                          | 23d. LOCATION (City or Town) <b>Baltimore, Maryland</b>                                                    |                                                                                                | (County) (State)                                                                                   |  |
| 24. FUNERAL DIRECTOR <b>Singleton Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                      | 25a. REC'D BY REGISTRAR <b>FEB 5 1969</b>                                                                  |                                                                                                                    | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                                                                                             |                                                                                                          |                                                                                                            |                                                                                                |                                                                                                    |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02020

CERTIFICATE OF DEATH

02015

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                            |  |                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Stephen</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | First <b>Stephen</b> Middle <b>Hart</b> Last <b>Hart</b>                                                                                                |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>24</b> Year <b>1969</b>                                                                                   |  | 2b. HOUR<br><b>2:15</b> a.m.                                                                 |  |                                                            |  |                                                                                   |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>white</b>                                                                                                                                 |  | 5. DATE OF BIRTH<br><b>July 14, 1904</b>                                                                                                                    |  | 6. AGE (In years<br>lost birthday)<br><b>64</b> YRS.                                         |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>           |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>15</b>                                 |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>N. J.</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                                                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                       |  | Md.                                                        |  |                                                                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>SPRING GROVE STATE HOSP.</b>                                         |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>radio engineer</b>                                            |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                         |  |                                                            |  |                                                                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY <b>Harford</b>                                                                                                                              |  | 13c. CITY OR TOWN<br><b>Aberdeen</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET AND NUMBER<br><b>Apt. 3 - Pritchard Avenue</b> |  |                                                                                   |  |
| 14. FATHER'S NAME<br><b>John</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | First <b>John</b> Middle <b></b> Last <b></b>                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br><b>Theresa</b>                                                                                                                  |  | First <b>Theresa</b> Middle <b></b> Last <b></b>                                             |  |                                                            |  |                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | (If yes give war or dates of service) <b></b>                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>714-09-6747</b>                                                                                                              |  | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>                                 |  | Address                                                    |  |                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral,</b><br><b>1639</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>pathology unknown.</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <b>Carcinoma of the left upper lobe, histo-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b></b><br>(b) <b></b><br>(c) <b></b> |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                            |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 month</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Neurosyphilis, treated.</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                            |  |                                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                        |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                      |  |                                                            |  |                                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b><br>P.M. <b></b>                                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |  |                                                            |  |                                                                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                                                         |  | 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>                                                                |  |                                                                                              |  |                                                            |  |                                                                                   |  |
| 22a. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Feb. 12, 1969</b> , to <b>Feb. 24, 1969</b> , that <b>(1)</b> (we) last<br>saw the deceased alive on <b>Feb. 24, 1969</b> , and that in (my) <b>(1)</b> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <b>(1)</b> (did not) view the body after death.                                                                                                         |  |                                                                                                                                                         |  |                                                                                                                                                             |  |                                                                                              |  |                                                            |  |                                                                                   |  |
| 22b. SIGNATURE<br><b>Anthony J. Young, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE <b></b> ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-24-69</b>                                                                                                                          |  |                                                                                              |  |                                                            |  |                                                                                   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Anthony J. Young, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b><br><b>Baltimore, Maryland 21228</b>                                                                     |  |                                                                                                                                                             |  |                                                                                              |  |                                                            |  |                                                                                   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE <b>3/3/69</b>                                                                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b>                                                                                                  |  | 23d. LOCATION (City or Town) <b>Old Frederick Bldg. Md.</b> (County) <b></b> (State) <b></b> |  |                                                            |  |                                                                                   |  |
| 24. FUNERAL DIRECTOR<br><b>KRAUSE FUNERAL HOME-1214 S. CHARLES ST.</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS <b>ST</b>                                                                                                                                       |  | 25a. REC'D BY REGISTRAR<br><b>MAR 6 1969</b>                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Young</b>                                             |  |                                                            |  |                                                                                   |  |

21050

05054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Medical Examiner

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 02021                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                            |                                                                                                                                        | 02016                                                                                                                                                       |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              | First<br><b>Edgar</b>                                                                                      |                                                                                                                                        | Middle<br><b>Ray</b>                                                                                                                                        |                                                                                                           | Last<br><b>Harvey</b>                                                                           |                                                                      | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>18</b> Year <b>1969</b> |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              | 4. RACE<br><b>White</b>                                                                                    |                                                                                                                                        | 5. DATE OF BIRTH<br><b>3-18-1896</b>                                                                                                                        |                                                                                                           |                                                                                                 | 6. AGE (In years last birthday)<br><b>72</b> RS.                     |                                                                           | 7b. HOUR<br><b>3:16</b><br>p.m.              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                            |                                                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                           | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |                                                                      |                                                                           |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |                                                                                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b> |                                                                                                 |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                         |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                   |  |                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                                            |                                                                                                                                        | 13c. CITY OR TOWN<br><b>Monkton</b>                                                                                                                         |                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER<br><b>Box 39, Hess Road #21111</b>                 |                                              |
| 14. FATHER'S NAME<br>First <b>Henry</b> Middle <b>Harvey</b> Last <b>Pearce</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First <b>Laura</b> Middle <b>Pearce</b> Last <b>Pearce</b>                     |                                                                                                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>Yes WW 1</b>                                                                                                                                                                                                                                                                                           |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>215-32-2883</b>                                                             |                                                                                                                                        | 17. INFORMANT<br>Address<br><b>Mrs. Ethel S. Harvey Same as 13 E</b>                                                                                        |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Irreversible shock due to</b><br><b>5320</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Bleeding duodenal ulcer.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONGESTIVE HEART FAILURE</b> |  |                                                                              |                                                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Congestive heart failure.</b>                                                                                                                                                                                                                             |  |                                                                              |                                                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 19a. DATE OF OPERATION<br><b>2-18-69</b>                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>G.I. bleeding</b>     |                                                                                                            |                                                                                                                                        |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                           |                                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |                                                                                                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                            | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                           |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 22a. I certify that (A) (this hospital) attended the deceased from <b>February 18, 1969</b> , to <b>February 18, 1969</b> , that (A) (we) last saw the deceased alive on <b>February 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |                                                                              |                                                                                                            |                                                                                                                                        |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 22b. SIGNATURE<br><b>Freidoon Malek M.D.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                            | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                                                                                                                                             |                                                                                                           |                                                                                                 | 22c. DATE SIGNED<br><b>February 18, 1969</b>                         |                                                                           |                                              |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Freidoon Malek, M.D.</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                                                            | 22e. ADDRESS<br><b>7620 York Road, Towson, Maryland 21204</b>                                                                          |                                                                                                                                                             |                                                                                                           |                                                                                                 |                                                                      |                                                                           |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>2-20-69</b>                                                  |                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. James Episcopal</b>                                                                       |                                                                                                                                                             |                                                                                                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Monkton Maryland</b>                        |                                                                      |                                                                           |                                              |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Wm. Cook-Brooks Towson, Inc. Towson, Md.</b>                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                                                            | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 20 1969</b>                                                                                  |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                                        |                                                                                                 |                                                                      |                                                                           |                                              |

31080

0585

XX 15

U. S. A.

Q

Monahan

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02022

CERTIFICATE OF DEATH

02017

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |                                                                                                                |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                             |                       |                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------|-------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                 | First<br><b>MARGARET</b>                                                                                       | Middle<br><b>F.</b>                                                                                                                                         | Lost<br><b>HAWKINS</b>                                                                                                          | 2a. DATE OF DEATH<br>February 13, 1969                                               |                                                                             | 2b. HOUR<br>2:00 P.M. |                                                 |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE<br><b>W</b>                             |                                                                                                                | 5. DATE OF BIRTH<br>January 9, 1895                                                                                                                         |                                                                                                                                 | 6. AGE (In years<br>lost birthday)<br><b>74</b> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS DAYS                                              |                       | IF UNDER 24 HRS.<br>HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |                                                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                 | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                           |                                                                             |                       |                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Woodlawn</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>1714 New Castle Road</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>                  |                                                                                      | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                        |                       |                                                 |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission): STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                               |                                                 | 13b. COUNTY<br><b>Baltimore</b>                                                                                |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Woodlawn</b>                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>1714 New Castle Road</b>                       |                       |                                                 |
| 14. FATHER'S NAME First Middle Last<br><b>William Heckrotte</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |                                                                                                                | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Martha Moran</b>                                                                                           |                                                                                                                                 |                                                                                      |                                                                             |                       |                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                                                                               |                                                 | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                              |                                                                                                                                                             | 17. INFORMANT Address<br><b>Mr. William H. Hawkins, 1714 New Castle Rd.</b>                                                     |                                                                                      |                                                                             |                       |                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) <b>Cerebral Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerotic Cardio Vase Disease</b> |                                                 |                                                                                                                |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                             |                       | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                     |                                                 |                                                                                                                |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                             |                       |                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                               |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                            |                                                                                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?     |                       |                                                 |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                           |                                                 | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                     |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                 |                                                                                      |                                                                             |                       |                                                 |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work                                                                                                                                                                                                                                                                                                                                       |                                                 | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                    |                                                                                      |                                                                             |                       |                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-14, 1968</b> , to <b>Feb 13, 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>Feb 12, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above (I) (we) (did) (did not) view the body after death.                                                                                                   |                                                 |                                                                                                                |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                             |                       |                                                 |
| 22b. SIGNATURE<br><b>Harry L. Knipp</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                 | DEGREE                                                                                                         |                                                                                                                                                             | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br><b>2-13-69</b>                                          |                       |                                                 |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Harry L. Knipp M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                 | 22e. ADDRESS<br><b>4116 Edmondson Avenue</b>                                                                   |                                                                                                                                                             | 22f. ADDRESS<br><b>21229</b>                                                                                                    |                                                                                      |                                                                             |                       |                                                 |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                 | 23b. DATE<br><b>2-15-1969</b>                                                                                  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                                                               |                                                                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |                       |                                                 |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                |                                                                                                                                                             | 25a. RECEIVED BY REGISTRAR<br><b>FEB 17 1969</b>                                                                                |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>DATE</b>                                   |                       |                                                 |

00000

00000

7

1



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02023

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02018

|                                                                                                                                                                                                                                                                                                                                                                                                                             |                         |                                                                                                            |                                                                        |                                                                                                                                                             |                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>Egberf E. Haymond</b>                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                            | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>February 20 1969</b>   |                                                                                                                                                             | 2b. HOUR<br>PM<br><b>1 P M</b>                                                |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>2-7-82</b>                                                                          | 6. AGE (In years last birthday)<br><b>87</b> YRS.                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>19 69</b>                                                                                                              | IF UNDER 24 HRS<br>HOURS MIN.<br><b>15</b>                                    |
| 7a. BIRTHPLACE (State or foreign country)<br><b>W. Virginia</b>                                                                                                                                                                                                                                                                                                                                                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                               |
| 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                            | 9d. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>February 20 19 69</b> |                                                                                                                                                             |                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>                                                   |                                                                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                            |                         | 13b. COUNTY<br><b>Baltimore</b>                                                                            |                                                                        | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                               |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Benjamin T. Haymond</b>                                                                                                                                                                                                                                                                                                                                                        |                         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Elizabeth Prince</b>                                   |                                                                        |                                                                                                                                                             |                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                          |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>234-42-2172</b>                    |                                                                        | 17. INFORMANT<br>ADDRESS<br><b>Wife: Myrtle same</b>                                                                                                        |                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>880X</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Thrombary Embolic Fracture of Left Hip</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                           |                         |                                                                                                            |                                                                        |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>8 Day</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                          |                         |                                                                                                            |                                                                        |                                                                                                                                                             |                                                                               |
| 19a. DATE OF OPERATION<br><b>2/17/69</b>                                                                                                                                                                                                                                                                                                                                                                                    |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fracture of left Hip</b>                            |                                                                        | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |                                                                               |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                           |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR AM P.M.<br><b>2/12/69</b>                                     |                                                                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Fell on Step at Home</b>                                              |                                                                               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                        |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>                |                                                                        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>7247 Sindall Rd Baltimore Co. Md</b>                                                     |                                                                               |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                            |                                                                        |                                                                                                                                                             |                                                                               |
| ACTUAL SIGNATURE<br><b>Charles O'Donnell</b>                                                                                                                                                                                                                                                                                                                                                                                |                         | M.D.<br><b>Charles O'Donnell, M.D.</b>                                                                     |                                                                        | 22b. DATE SIGNED<br><b>2/20/69</b>                                                                                                                          |                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>                                                                                                                                                                                                                                                                                                                                                              |                         | 23b. DATE<br><b>2/24/69</b>                                                                                |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>                                                                                         |                                                                               |
| 24. FUNERAL DIRECTOR<br><b>Wm. E. Johnson</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | ADDRESS<br><b>8521 Loch Raven Blvd., 21204</b>                                                             |                                                                        | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co., Maryland</b>                                                                             |                                                                               |
| 25a. REC'D BY REGISTRAR<br><b>FEB 24 1969</b>                                                                                                                                                                                                                                                                                                                                                                               |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Charles O'Donnell</b>                                                     |                                                                        |                                                                                                                                                             |                                                                               |

03018

03018

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 | 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 | 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 | 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 | 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 | 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 | 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15  
30M REV. 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                            |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                            |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
| 02024                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                                            |                                                                                                                                                          | 02019                                                                                                                                  |                                                                                              |                                                                      |                                                              |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                            |                                                                                                                                                          | 2a. DATE OF DEATH                                                                                                                      |                                                                                              |                                                                      | 2b. HOUR                                                     |  |
| First Middle Last<br><b>William F. Heffner</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |                                            |                                                                                                                                                          | Month Day Year<br><b>February 1, 1969</b>                                                                                              |                                                                                              |                                                                      | 9:30AM                                                       |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                      |                                            | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                        | 6. AGE (In years lost birthday)                                                              |                                                                      | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.      |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                      |  | White                                                                        |                                            | March 13, 1889                                                                                                                                           |                                                                                                                                        | 79 YRS.                                                                                      |                                                                      |                                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH                                                                           |                                                                      |                                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                 |  | USA                                                                          |                                            |                                                                                                                                                          |                                                                                                                                        | Baltimore County                                                                             |                                                                      | Md.                                                          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                            | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |                                                                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                                                      |                                                              |  |
| Overlea                                                                                                                                                                                                                                                                                                                                                                                                   |  | 109 East Overlea Ave.                                                        |                                            | Service Dept                                                                                                                                             |                                                                                                                                        | Laundry                                                                                      |                                                                      |                                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY                                                                  |                                            | 13c. CITY OR TOWN                                                                                                                                        |                                                                                                                                        | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER                                       |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                  |  | Baltimore Co.                                                                |                                            | Overlea                                                                                                                                                  |                                                                                                                                        |                                                                                              |                                                                      | 109 East Overlea Ave.                                        |  |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
| Frank Heffner                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              | Louise Lynn                                |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                   |  |                                                                              | 16b. SOCIAL SECURITY NO.                   |                                                                                                                                                          | 17. INFORMANT Address                                                                                                                  |                                                                                              |                                                                      |                                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | 215-01-6999                                |                                                                                                                                                          | Barbara F. Heffner 109 E. Overlea Ave.                                                                                                 |                                                                                              |                                                                      |                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerosis Cardiovascular</u><br><u>4124</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                     |  |                                                                              |                                            |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Under</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                       |  |                                                                              |                                            |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                            |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                              |  |
| -----                                                                                                                                                                                                                                                                                                                                                                                                     |  | -----                                                                        |                                            |                                                                                                                                                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                    |                                                                                              | -----                                                                |                                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year                                 |                                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  | P.M. 19                                                                      |                                            | -----                                                                                                                                                    |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                            | 21f. LOCATION Street or R.F.D. No.                                                                                                                       |                                                                                                                                        | City or Town                                                                                 |                                                                      | County State                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                           |  | -----                                                                        |                                            | -----                                                                                                                                                    |                                                                                                                                        | -----                                                                                        |                                                                      | -----                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-7-3</u> , 19 <u>56</u> , to <u>2-1</u> , 19 <u>69</u> , that (I) (we) lost the deceased on <u>29 Jan</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Dr. S. J. Allen viewed &amp; signed death</u> |  |                                                                              |                                            |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                                              |  |
| 22b. SIGNATURE <u>John E. Hyle</u>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                            |                                                                                                                                                          | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                              | 22c. DATE SIGNED <u>Feb., 3, 1969</u>                                |                                                              |  |
| 22d. PHYSICIAN'S NAME (Type) <u>John E. Hyle M.D.</u>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                                            |                                                                                                                                                          | 22e. ADDRESS <u>7527 Belair Road Balto., Co., Md.</u>                                                                                  |                                                                                              |                                                                      |                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                    |                                            | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                                                                        | 23d. LOCATION (City or Town) (County) (State)                                                |                                                                      |                                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                    |  | Feb. 4, 1969                                                                 |                                            | Gardens of Faith Cem.                                                                                                                                    |                                                                                                                                        | Baltimore Co., Md.                                                                           |                                                                      |                                                              |  |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                            |                                                                                                                                                          | 25a. RECEIVED BY REGISTRAR DATE                                                                                                        |                                                                                              | 25b. REGISTRAR'S SIGNATURE                                           |                                                              |  |
| Dippel Brothers Inc. 7110 Belair Rd. 21206                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                            |                                                                                                                                                          | FEB 5 1969                                                                                                                             |                                                                                              | <u>Charles Judge</u>                                                 |                                                              |  |

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV.

| MIDDLE                                                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 02025                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 02020                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                     |  |  | First<br>ADA                                                                                                  |  |  | Middle<br>E.                                                                                                                                                |  |  | Last<br>HEIL                                                                                    |  |  | 2a. DATE OF DEATH<br>Month 02 Day 07 Year 69                                                                                             |  |  | 2b. HOUR<br>1:30 M                        |  |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                        |  |  | 4. RACE<br>White                                                                                              |  |  | 5. DATE OF BIRTH<br>Aug. 28, 1905.                                                                                                                          |  |  | 6. AGE (In years<br>lost birthday)<br>63 YRS.                                                   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                                                                                |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland                                                                                                                                                                                                                                                                                                                                |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                           |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE                                                                 |  |  | Md.                                                                                                                                      |  |  |                                           |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE                                                                                                                                                                                                                                                                                                                                                  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>GREATER BALTO. MED. CENTER |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Dept. Store                                           |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.                                                                                                                                                                                                                                                                                 |  |  | 13b. COUNTY<br>BALTIMORE                                                                                      |  |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>5830 Leith Walk                                                                                                |  |  |                                           |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Louis Harps                                                                                                                                                                                                                                                                                                                                   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ada L. ?                                                        |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No                                                                                     |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>215-07-2511                |  |  | 17. INFORMANT<br>Mr. Leo A. Heil                                                                                                         |  |  | Address<br>(Same)                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT LUNG WITH WIDE-<br>SPREAD METASTASES<br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 YR.                                                                                 |  |  |                                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                     |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                    |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>1/31 69 2/7 69                                                                              |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/7, 1969, to 2/7, 1969, that (I) (we) last<br>saw the deceased alive on 2/7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                                                      |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 22b. SIGNATURE<br>Derek H. Bruce M.B.C.H.B. DEGREE                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>2/7/69                |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>D. BRUCE                                                                                                                                                                                                                                                                                                                                             |  |  | 22e. ADDRESS<br>G.B.M.C.                                                                                      |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                  |  |  | 23b. DATE<br>2/12/69.                                                                                         |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery                                                                                                     |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |                                                                                                                                          |  |  |                                           |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Leona rd J. Ruck, Inc. Balto. Md. 212 14                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                               |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 10 1969                                                                                                                 |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                                     |  |  |                                                                                                                                          |  |  |                                           |  |  |



03030

03030

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                         |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ARTHUR</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         | First <b>H.</b>                                                                                           |  | Middle <b>H.</b>                                                                                                                                            |  | Last <b>HERBST</b>                                                                           |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>Feb. 21, 1969</b> |  | 2b. HOUR ? <input type="checkbox"/> M                                                                       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Jan. 7, 1905</b>                                                                   |  | 6. AGE (In years last birthday) <b>64 YRS.</b>                                                                                                              |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>             |  | IF UNDER 24 HRS<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                                                                                 |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb.</b> Day <b>21</b> , Year <b>1969</b> ? <input type="checkbox"/> M |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                            |                         | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                   |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. County General</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Plant Supt.</b>                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Jenkins Mem. Hospt.</b>                                 |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                          |                         | 13b. COUNTY <b>Baltimore</b>                                                                              |  | 13c. CITY OR TOWN <b>Rock Dale</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8333 Merrymount Drive</b>                                                                                                          |  |                                                                                                             |  |
| 14. FATHER'S NAME<br><b>Arthur H. Herbst Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                       |                         |                                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br><b>Bessie Howard</b>                                                                                                            |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) <b>NO</b>                                                                                                                                                                                                                                                                                                                                       |                         | 16b. SOCIAL SECURITY NO.<br><b>215-01-3763</b>                                                            |  | 17. INFORMANT ADDRESS<br><b>Anita Herbst 8333 Merrymount Dr. Rock Dale</b>                                                                                  |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                       |                         |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |                         |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                              |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                |  |                                                                                                             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                       |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                                                                        |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |  |                                                                                                                                                                 |  |                                                                                                             |  |
| ACTUAL SIGNATURE<br><b>Edward F. Wilson</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         | EXAMINER'S NAME (Type)<br><b>Edward F. Wilson, M.D.</b>                                                   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                             |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                               |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                |  | 22b. DATE SIGNED<br><b>2/21/69</b>                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                         | 23b. DATE<br><b>Feb. 24, 69</b>                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cem.</b>                                                                                             |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Maryland Balto. Co.</b>         |  |                                                                                                                                                                 |  |                                                                                                             |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers</b>                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                           |  | ADDRESS<br><b>8728 Liberty Rd. Randallstown.</b>                                                                                                            |  |                                                                                              |  | 25a. REC'D BY REGISTRAR<br><b>FEB 24 1969</b>                                                                                                                   |  | 25b. REGISTRAR'S SIGNATURE                                                                                  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                     |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--|
| 02027                                                                                                                                                                                                                                                                                                                                                           |  | 02022 |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| 1. DECEASED-NAME (Type or print) <b>HENRY</b>                                                                                                                                                                                                                                                                                                                   |  |       |  |                                                                              |  | First <b>HERING</b>                                                                                   |  |                                                                                 | Last                                                                                                                                                     |                                                                      |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                              |  |       |  |                                                                              |  | 4. RACE <b>White</b>                                                                                  |  |                                                                                 | 5. DATE OF BIRTH <b>9-23-1896</b>                                                                                                                        |                                                                      |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                       |  |       |  |                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                            |  |                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                      |  |
| 10. CITY OR TOWN OF DEATH <b>Arbutus</b>                                                                                                                                                                                                                                                                                                                        |  |       |  |                                                                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1255 Maple Avenue</b> |  |                                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Glass Worker</b>                                      |                                                                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                   |  |       |  |                                                                              |  | 13b. COUNTY <b>Baltimore</b>                                                                          |  |                                                                                 | 13c. CITY OR TOWN <b>Arbutus</b>                                                                                                                         |                                                                      |  |
| 14. FATHER'S NAME First <b>Frank</b> Middle <b>Hering</b> Last                                                                                                                                                                                                                                                                                                  |  |       |  |                                                                              |  | 15. MOTHER'S MAIDEN NAME First <b>Pauline</b> Middle <b>Keller</b> Last                               |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                              |  |       |  |                                                                              |  | 16b. SOCIAL SECURITY NO. <b>218-03-9947</b>                                                           |  |                                                                                 | 17. INFORMANT Address <b>Mrs. Margaret Daughaday, 1255 Maple Ave.</b>                                                                                    |                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                       |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>                                                                                                                                                                                                                                                                                      |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                             |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                           |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                              |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                          |  |       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                                                                                       |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                                                                                                                                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                              |  |       |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |  |                                                                                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                                                                                                          |                                                                      |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                         |  |       |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                                                                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                                                                                                          |                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>Feb</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>7 Feb</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |       |  |                                                                              |  |                                                                                                       |  |                                                                                 |                                                                                                                                                          |                                                                      |  |
| 22b. SIGNATURE <b>William Goodman</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                    |  |       |  |                                                                              |  |                                                                                                       |  | 22c. DATE SIGNED                                                                |                                                                                                                                                          |                                                                      |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. William Goodman</b>                                                                                                                                                                                                                                                                                                         |  |       |  |                                                                              |  |                                                                                                       |  | 22e. ADDRESS <b>1334 Sulphur Spring Road, Balto., Md.</b>                       |                                                                                                                                                          |                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                         |  |       |  | 23b. DATE <b>2-10-1969</b>                                                   |  |                                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>                  |                                                                                                                                                          |                                                                      |  |
| 24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>                                                                                                                                                                                                                                                                                                |  |       |  | 25a. REC'D BY REGISTRAR <b>21229</b>                                         |  |                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE <b>FEB 10 1969</b>                                   |                                                                                                                                                          |                                                                      |  |
| 23d. LOCATION (City or Town) <b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                         |  |       |  | 23e. (County) <b>Baltimore</b>                                               |  |                                                                                                       |  | 23f. (State) <b>Md.</b>                                                         |                                                                                                                                                          |                                                                      |  |

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

10-1-47

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| 02028                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                            |  |  |  |  |  |  |  |  |  | 02023                                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                                                                                                                      |  |  |  |  |  |  |  |  |  | 2b. HOUR                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| Daniel                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | Month 2 Day 5 Year 69                                                                                                                  |  |  |  |  |  |  |  |  |  | 7:15 <sup>A</sup> M                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 3. SEX Male                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 4. RACE White                                                                                                                          |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH Nov. 7, 1958                                                                                                                            |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday) 10 YRS.                                                      |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                    |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH Baltimore Md.                                                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH Owings Mills                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital                                   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none                                                             |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 13b. COUNTY Montgomery                                                                                                                 |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN Kensington                                                                                                                             |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 13e. STREET AND NUMBER 10909 Jolly Way                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 14. FATHER'S NAME First Middle Last David Michael Hershfield                                                                           |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last Julia - DeGRAZIA                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. ---                                                                                                           |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address Rosewood Records, Owings Mills, Md.                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                           |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 7593 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | (b) Aspiration of Gastric Contents                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| lost.                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | (c)                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| institutionalized 5 yrs. Mongolism                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                       |  |  |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                                                                   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                           |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/4/1963, to 2/5/1969, that (I) (we) last saw the deceased alive on 2/5/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Richard A. Jones                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 5 Feb 69                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 22e. ADDRESS Rosewood State Hosp., Owings Mills, Md                                                                                    |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 23b. DATE Feb. 6, 1969                                                                                                                 |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory                                                                                                |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) Washington 18, D.C.                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR H. J. Schhardt                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | ADDRESS Owings Mills, Md.                                                                                                              |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE FEB 7 1969                                                                                                                  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge                                                     |  |  |  |  |  |  |  |  |  |

2306

05020

• 1010 •

→ 100% → 100%



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02029

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02024

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                      |                                                                                                                   |                                   |                                 |                                                                                                                                                             |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Dr. Leon Hughes Hetherington</b>                                                                                                                                                                                                                                                                                                                                                                |                             |                                      | 2a. DATE KNOWN OF DEATH<br>Month <b>February</b> Day <b>9</b> Year <b>1969</b>                                    |                                   |                                 | 2b. HOUR<br><b>4 P M</b>                                                                                                                                    |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE<br><b>Caucasian</b> | 5. DATE OF BIRTH<br><b>10-7-1900</b> | 6. AGE (In years last birthday)<br><b>68</b> YRS.                                                                 | IF UNDER 1 YEAR<br>MONTHS<br>DAYS | IF UNDER 24 HRS<br>HOURS<br>MIN | 2c. DATE PRONOUNCED DEAD<br>Month <b>February</b> Day <b>9</b> Year <b>1969</b>                                                                             |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                       |                             |                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                     |                                   |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                             |                             |                                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balt. Medical Cen.</b> |                                   |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Physician</b>                                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                               |                             |                                      | 13b. COUNTY<br><b>Baltimore</b>                                                                                   |                                   |                                 | 13c. CITY OR TOWN<br><b>Ruxton</b>                                                                                                                          |  |  |
| 14. FATHER'S NAME<br>First <b>Thomas</b> Middle <b>A.</b> Last <b>Hetherington</b>                                                                                                                                                                                                                                                                                                                                                     |                             |                                      | 15. MOTHER'S MAIDEN NAME<br>First <b>Minnie</b> Middle <b>Huffman</b> Last <b>Huffman</b>                         |                                   |                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>                                                                                                                                                                                                                                                                                                                                                        |                             |                                      | 16b. SOCIAL SECURITY NO.<br><b>218-36-8075</b>                                                                    |                                   |                                 | 17. INFORMANT<br><b>Mrs. Helen A. Hetherington</b> Same as # <b>13 E</b>                                                                                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aortic Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Renal Vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                             |                                      |                                                                                                                   |                                   |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                                                                                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |                             |                                      |                                                                                                                   |                                   |                                 |                                                                                                                                                             |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                             |                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                 |                                   |                                 | 20. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                          |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                             |                                      | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>                                               |                                   |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                 |                             |                                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                      |                                   |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                             |                                      |                                                                                                                   |                                   |                                 |                                                                                                                                                             |  |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>                                                                                                                                                                                                                                                                                                                                                                                        |                             |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                   |                                   |                                 | 22b. DATE SIGNED<br><b>2/10/69</b>                                                                                                                          |  |  |
| EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>                                                                                                                                                                                                                                                                                                                                                                                     |                             |                                      | M.D.                                                                                                              |                                   |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                 |  |  |
| ADDRESS<br><b>Wm. Cook-Brooks Towson Inc. Towson, Md.</b>                                                                                                                                                                                                                                                                                                                                                                              |                             |                                      | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                        |                                   |                                 | 23b. DATE<br><b>2-12-69</b>                                                                                                                                 |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |                             |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Mem. Garden</b>                                           |                                   |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville Md.</b>                                                                                    |  |  |
| 25a. REC'D BY REGISTRAR<br><b>FEB 13 1969</b>                                                                                                                                                                                                                                                                                                                                                                                          |                             |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>William Cook-Brooks</b>                                                          |                                   |                                 |                                                                                                                                                             |  |  |

82082

82082

HEALTH DEPT  
STATE

on rin con

in 0-7-00

U.S.A.

h 1000

1000

1000

2-1-07

2-2-

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-60

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                 |  |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                 |  |                                                 |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                 |  |                                                 |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>MARGARET ELIZABETH HEYNE</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                     |  |                                                                                                                                                  |  | 2a. DATE OF DEATH<br>Month <b>02</b> Day <b>13</b> Year <b>69</b>                               |  | 2b. HOUR<br><b>2:05</b> M                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                             |  | 5. DATE OF BIRTH<br><b>7-6-13</b><br><del>July 6, 1913</del>                                                                                     |  | 6. AGE (In years lost birthday)<br><b>55</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                          |  | Md.                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balt. Med. Seceta ry</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Seceta ry</b>                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |                                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>Balto.</b>                                                                                        |  | 13c. CITY OR TOWN<br><b>Parkville</b>                                                                                                            |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>8407 Nunley Dr</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Charles P Heyne</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna B Winter</b>                                                                               |  |                                                                                                 |  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>212-01-5805</b>                                                                      |  | 17. INFORMANT Address<br><b>Mary Heyne 2730 Louise Ave</b>                                                                                       |  |                                                                                                 |  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE METASTATIC CANCER OF BREAST</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                          |  |                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                 |  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 69                                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                  |  |                                                                                                 |  |                                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                     |  |                                                                                                 |  |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> , 19 <b>69</b> , to <b>2/13</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                 |  |                                                 |  |
| 22b. SIGNATURE<br><b>B. Eslami</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                     |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>           |  | 22c. DATE SIGNED<br><b>2/13/69</b>                                                              |  |                                                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>B. ESLAMI</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                     |  | 22e. ADDRESS                                                                                                                                     |  |                                                                                                 |  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>2/15/69</b>                                                                                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |                                                 |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Leonard J Ruck Inc Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                     |  | 25a. REC'D BY REGISTRAR<br><b>FEB 14 1969</b>                                                                                                    |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. [unclear]</i>                                       |  |                                                 |  |

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

TO THE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

FROM THE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

BY: [Illegible]

FOR THE SECRETARY OF AGRICULTURE, WASHINGTON, D. C.

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                        |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| 02031                                                                                                                                                                                                                                                                                                                              |  |                              |                                                                              |                                                                                                                                                          | 02026             |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                   |  |                              |                                                                              |                                                                                                                                                          | 2a. DATE OF DEATH |                                                                                         |                                                                     | 2b. HOUR                                       |                                                                      |                                              |  |
| TERESA HOLZSCHUH                                                                                                                                                                                                                                                                                                                   |  |                              |                                                                              |                                                                                                                                                          | FEBRUARY 16, 1969 |                                                                                         |                                                                     | 11:30 P                                        |                                                                      |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                             |  | 4. RACE                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                   |                                                                                         | 6. AGE (In years lost birthday)                                     |                                                | IF UNDER 1 YEAR                                                      |                                              |  |
| FEMALE                                                                                                                                                                                                                                                                                                                             |  | WHITE                        |                                                                              | NOVEMBER 30, 1893                                                                                                                                        |                   |                                                                                         | 75 YRS.                                                             |                                                | MONTHS DAYS HOURS MIN                                                |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |                                                                                         | 9. COUNTY OF DEATH                                                  |                                                |                                                                      |                                              |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                           |  | U.S.A.                       |                                                                              |                                                                                                                                                          |                   |                                                                                         | BALTIMORE, Md.                                                      |                                                |                                                                      |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                          |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                     |                                                | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                              |  |
| TOWSON                                                                                                                                                                                                                                                                                                                             |  |                              | ST. JOSEPH HOSPITAL                                                          |                                                                                                                                                          |                   | HOMEMAKER                                                                               |                                                                     |                                                |                                                                      |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                      |  |                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN |                                                                                         | 13d. INSIDE CITY LIMITS?                                            |                                                | 13e. STREET AND NUMBER                                               |                                              |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                           |  |                              | BALTIMORE                                                                    |                                                                                                                                                          | Baltimore         |                                                                                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                | 620 OVERBROOK RD. #21212                                             |                                              |  |
| 14. FATHER'S NAME First Middle Lost                                                                                                                                                                                                                                                                                                |  |                              |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Lost                                                                                                               |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| Charles Fritz                                                                                                                                                                                                                                                                                                                      |  |                              |                                                                              | Unknown                                                                                                                                                  |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                                   |  |                              |                                                                              | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                   | 17. INFORMANT Address                                                                   |                                                                     |                                                |                                                                      |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                 |  |                              |                                                                              | 214-18-3638B                                                                                                                                             |                   | Mr. Otto J. Holzschuh                                                                   |                                                                     |                                                |                                                                      | (Same)                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                          |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE, MASSIVE PULMONARY EMBOLISM                                                                                                                                                                                                                                                 |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF (b) PHLEBOTHROMBOSIS                                                                                                                                                                                                                                                                           |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE                                                                                                                                                          |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                 |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| STATUS POST CHOLECYSTECTOMY                                                                                                                                                                                                                                                                                                        |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                             |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                                                          |                   | 20a. AUTOPSY?                                                                           |                                                                     |                                                | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |  |
| 2-3-69                                                                                                                                                                                                                                                                                                                             |  |                              | ACUTE CHOLECYSTLITHIASIS                                                     |                                                                                                                                                          |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                                                                     |                                                |                                                                      |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                 |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                                                                                                          |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                                                     |                                                |                                                                      |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                           |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                                                                          |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                                                     |                                                |                                                                      |                                              |  |
| 22a. I certify that (X) (this hospital) attended the deceased from January 29, 1969, to February 16, 1969, that (X) (we) last saw the deceased alive on February 16, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      |                                              |  |
| 22b. SIGNATURE <i>Elfron A. Quitiquit</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                   |  |                              |                                                                              |                                                                                                                                                          |                   |                                                                                         |                                                                     |                                                |                                                                      | 22c. DATE SIGNED February 17, 1969           |  |
| 22d. PHYSICIAN'S NAME (Type) Elfron A. Quitiquit, M.D.                                                                                                                                                                                                                                                                             |  |                              |                                                                              |                                                                                                                                                          |                   | 22e. ADDRESS 7620 York Road Towson, Md. #21204                                          |                                                                     |                                                |                                                                      |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                          |  | 23b. DATE                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                   |                                                                                         | 23d. LOCATION (City or Town) (County) (State)                       |                                                |                                                                      |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                             |  | 2/19/69.                     |                                                                              | Holy Redeemer Cemetery                                                                                                                                   |                   |                                                                                         | Baltimore, Md.                                                      |                                                |                                                                      |                                              |  |
| 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214                                                                                                                                                                                                                                                                |  |                              |                                                                              |                                                                                                                                                          |                   | 25. REC'D BY REGISTRAR DATE 19 1969                                                     |                                                                     | 26. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |                                                                      |                                              |  |

1000

STATE OF NEW YORK

1000

11

IN SENATE

January 10, 1900

REPORT

OF THE

COMMISSIONERS

(1899)

OF THE LAND OFFICE

AND OF THE

1

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

PRINTED BY THE STATE OF NEW YORK, 1900.

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

PRINTED BY THE STATE OF NEW YORK, 1900.

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

PRINTED BY THE STATE OF NEW YORK, 1900.

ALBANY: PUBLISHED BY THE STATE OF NEW YORK, 1900.

PRINTED BY THE STATE OF NEW YORK, 1900.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              | First Middle Last<br>Charles Howard Hood                                                                 |                                                                                                                                                             |                                                                                                        | 2a. DATE OF DEATH<br>Month Day Year<br>February 18, 1969                                           |                                                                                      |                                                    | 2b. HOUR<br>9:10 a. M                             |
| 3. SEX<br>male                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE<br>white                                                             |                                                                                                          | 5. DATE OF BIRTH<br>Nov. 25, 1885                                                                                                                           |                                                                                                        |                                                                                                    | 6. AGE (In years last birthday)<br>83 YRS.                                           |                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.                                        |                                                                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                        | 9. COUNTY OF DEATH<br>Baltimore Md.                                                                |                                                                                      |                                                    |                                                   |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SPRING GROVE STATE HOSP. |                                                                                                                                                             |                                                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>retired |                                                                                      |                                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>fed. employe |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.                                                                                                                                                                                                                                                                                                                              |  |                                                                              | 13b. COUNTY<br>Balto.                                                                                    |                                                                                                                                                             | 13c. CITY OR TOWN<br>Woodlawn                                                                          |                                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                    | 13e. STREET AND NUMBER<br>2010 Woodlawn Drive     |
| 14. FATHER'S NAME<br>First Middle Last<br>John T. Hood                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Ruth Skiolex Warfield                                   |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>Canadian Army WW I                                                                                                                                                                                                                                                                                                 |  |                                                                              | 16b. SOCIAL SECURITY NO.<br>218-10-5922A                                                                 |                                                                                                                                                             | 17. INFORMANT<br>Jennie C. Hood-2010 Woodlawn Drive #7<br>Address<br>Records: SPRING GROVE STATE HOSP. |                                                                                                    |                                                                                      |                                                    |                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia; left lower lobe</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                          |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |                                                                                                    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |                                                    |                                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16</u> , 19 <u>69</u> , to <u>Feb. 18</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                       |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        |                                                                                                    |                                                                                      |                                                    |                                                   |
| 22b. SIGNATURE<br><i>Anthony J. Young</i><br>DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                                                                               |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        | 22c. DATE SIGNED<br>2-18-69                                                                        |                                                                                      |                                                    |                                                   |
| 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                           |                                                                                      |                                                    |                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br>2-20-69                                                         |                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cem                                                                                                |                                                                                                        |                                                                                                    | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                 |                                                    |                                                   |
| 24. FUNERAL DIRECTOR<br>Marion Armacost-4600 Liberty Hghts. Avenue                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                          |                                                                                                                                                             |                                                                                                        | 25a. REC'D BY REGISTRAR<br>FEB 20 1969                                                             |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |                                                   |

MEDICAL CERTIFICATION

SEAS

[illegible]

528

— — — — —

1111

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00  
03  
1

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                              |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                      |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                             |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                 |           | First                                                                        |                          | Middle                                                                                                                                                   |                                                                                        | Last                                                                                         |                                                                      | 2a. DATE OF DEATH                                                                                                               |  | 2b. HOUR                                     |
| Rosalie                                                                                                                                                                                                                                                                                                          |           | McKnew                                                                       |                          | HORNER                                                                                                                                                   |                                                                                        | February                                                                                     |                                                                      | Month Day Year 18 1969                                                                                                          |  | 12:20 AM                                     |
| 3. SEX                                                                                                                                                                                                                                                                                                           | 4. RACE   |                                                                              | 5. DATE OF BIRTH         |                                                                                                                                                          |                                                                                        | 6. AGE (In years last birthday)                                                              |                                                                      | IF UNDER 1 YEAR                                                                                                                 |  | IF UNDER 24 HRS.                             |
| Female                                                                                                                                                                                                                                                                                                           | Caucasian |                                                                              | 22 June 1904             |                                                                                                                                                          |                                                                                        | 64 YRS.                                                                                      |                                                                      | MONTHS DAYS                                                                                                                     |  | HOURS MIN.                                   |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                        |           | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                        | 9. COUNTY OF DEATH                                                                           |                                                                      |                                                                                                                                 |  |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                        |           | USA                                                                          |                          |                                                                                                                                                          |                                                                                        | Baltimore Md.                                                                                |                                                                      |                                                                                                                                 |  |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                        |           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                                                                                                                 |  |                                              |
| Monkton                                                                                                                                                                                                                                                                                                          |           | Monkton Rd                                                                   |                          |                                                                                                                                                          | Housewife                                                                              |                                                                                              | Same                                                                 |                                                                                                                                 |  |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE                                                                                                                                                                                                                   |           | 13b. COUNTY                                                                  |                          | 13c. CITY OR TOWN                                                                                                                                        |                                                                                        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER                                                                                                          |  |                                              |
| Md                                                                                                                                                                                                                                                                                                               |           | Balt                                                                         |                          | Monkton                                                                                                                                                  |                                                                                        |                                                                                              |                                                                      | Monkton Rd                                                                                                                      |  |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                |           |                                                                              | 15. MOTHER'S MAIDEN NAME |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| Charles W <sup>m</sup> McKnew                                                                                                                                                                                                                                                                                    |           |                                                                              | Julia May Hale           |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)                                                                                                                                                                                                                                               |           |                                                                              | 16b. SOCIAL SECURITY NO. |                                                                                                                                                          | 17. INFORMANT                                                                          |                                                                                              | Address                                                              |                                                                                                                                 |  |                                              |
| No                                                                                                                                                                                                                                                                                                               |           |                                                                              | —                        |                                                                                                                                                          | Daughter Mary Ellen                                                                    |                                                                                              | Same                                                                 |                                                                                                                                 |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                        |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                     |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| IMMEDIATE CAUSE (a) Carcinoma tons                                                                                                                                                                                                                                                                               |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  | 1966                                         |
| 174 X DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                             |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                   |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| (b) Cancer of Breast                                                                                                                                                                                                                                                                                             |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  | 1951                                         |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                   |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| (c)                                                                                                                                                                                                                                                                                                              |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                               |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                           |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                                                                                              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                                                                                 |  |                                              |
|                                                                                                                                                                                                                                                                                                                  |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                               |           | 21b. TIME OF INJURY                                                          |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
|                                                                                                                                                                                                                                                                                                                  |           | HOUR A.M. Month Day Year P.M. 19                                             |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                          |           | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION                                                                                                                                            |                                                                                        | Street or R.F.D. No.                                                                         |                                                                      | City or Town                                                                                                                    |  | County State                                 |
|                                                                                                                                                                                                                                                                                                                  |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 49, to Feb 19 69, that (I) (we) last saw the deceased alive on 17 February 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                   |           |                                                                              |                          |                                                                                                                                                          |                                                                                        | DEGREE                                                                                       |                                                                      | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                             |
| Walter T. Kees                                                                                                                                                                                                                                                                                                   |           |                                                                              |                          |                                                                                                                                                          |                                                                                        |                                                                                              |                                                                      |                                                                                                                                 |  | 18 February 1969                             |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                     |           |                                                                              |                          |                                                                                                                                                          |                                                                                        | 22e. ADDRESS                                                                                 |                                                                      |                                                                                                                                 |  |                                              |
| WALTER T. KEES                                                                                                                                                                                                                                                                                                   |           |                                                                              |                          |                                                                                                                                                          |                                                                                        | Cockeysville, Md                                                                             |                                                                      |                                                                                                                                 |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                        |           | 23b. DATE                                                                    |                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                        | 23d. LOCATION (City or Town)                                                                 |                                                                      | (County)                                                                                                                        |  | (State)                                      |
| Burial                                                                                                                                                                                                                                                                                                           |           | 2/20/68                                                                      |                          | Trinity Episcopal Cem.                                                                                                                                   |                                                                                        | Long Green, Md.                                                                              |                                                                      |                                                                                                                                 |  |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                             |           |                                                                              |                          |                                                                                                                                                          |                                                                                        | 25a. REC'D BY REGISTRAR                                                                      |                                                                      | 25b. REGISTRAR'S SIGNATURE                                                                                                      |  |                                              |
| James J. Hartman, New Freedom, Pa.                                                                                                                                                                                                                                                                               |           |                                                                              |                          |                                                                                                                                                          |                                                                                        | DATE FEB 25 1969                                                                             |                                                                      | Charles J. J...                                                                                                                 |  |                                              |

MEDICAL CERTIFICATION

05003

DEPARTMENT OF PLANT

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

05003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02029

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                                                                                                                                                             |                                                                                              |                                                                                            |                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Lillian May Howes                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                                                             | 2a. DATE OF DEATH Month Day Year<br>Feb 13 1969                                              |                                                                                            | 2b. HOUR<br>12:12 PM                                       |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. RACE<br>white                                                                                 | 5. DATE OF BIRTH<br>July 26, 1888                                                                                                                           |                                                                                              | 6. AGE (In years last birthday)<br>80 YRS.                                                 | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore Md.                                                          |                                                                                            |                                                            |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>118 Stonewall Rd | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>housewife                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br>at home                                                 |                                                                                            |                                                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                          | 13b. COUNTY<br>Baltimore                                                                         | 13c. CITY OR TOWN<br>Catonsville                                                                                                                            | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br>118 Stonewall Rd.                                                |                                                            |
| 14. FATHER'S NAME First Middle Last<br>Phillip Krause                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Johanna Iager                                                                                                 |                                                                                              |                                                                                            |                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  | 16b. SOCIAL SECURITY NO.<br>220 48 9960                                                                                                                     |                                                                                              | 17. INFORMANT Address<br>Robert I. Howes 1802 Newcastle Rd, Baltimore, Md. 21207           |                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>4122 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial Hypertensive Cardio Vascular Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hrs<br>19 days<br>10 yrs |                                                                                                  |                                                                                                                                                             |                                                                                              |                                                                                            |                                                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Fracture of clavicle &amp; ribs right. pneumonia lower lobe</u>                                                                                                                                                                                                                                                                                                          |                                                                                                  |                                                                                                                                                             |                                                                                              |                                                                                            |                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                              | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                                                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                          |                                                                                                  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19<br>2/4/69                                                                                              |                                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)<br>2/15/69 |                                                            |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/4/69 to 2/15/69, that (I) (we) last saw the deceased alive on 2/15/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                               |                                                                                                  |                                                                                                                                                             |                                                                                              |                                                                                            |                                                            |
| 22b. SIGNATURE<br>W E McGrath MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  | 22c. DATE SIGNED<br>2/17/69                                                                                                                                 |                                                                                              | 22d. PHYSICIAN'S NAME (Type)<br>W E McGrath MD                                             |                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 23b. DATE<br>2 18 1969                                                                                                                                      |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem.                                     |                                                            |
| 24. FUNERAL DIRECTOR<br>Higginbotham Slack<br>Funeral Home                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  | 24b. ADDRESS<br>3871 Old Columbia Pk. ELLIOTT & S. Md.                                                                                                      |                                                                                              | 25a. REC'D BY REGISTRAR<br>DATE FEB 20 1969                                                |                                                            |
| 25b. REGISTRAR'S SIGNATURE<br>K. Charles Young                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  | 25c. LOCATION (City or Town) (County) (State)<br>Elkridge Howard Maryland                                                                                   |                                                                                              |                                                                                            |                                                            |

03032

THE NIGHT OF MARCH

03032

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "March" and "night" are faintly visible.]*

03032



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                        |                  |                                                                                                  |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       | 02030                                                                               |                                              |                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|-----------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                            |                  |                                                                                                  |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                  | First<br>ELMER                                                                                                    |                                                                                                                                                             | Middle<br>WARREN |                                                                                                            | Last<br>HUFFINGTON |                                                                       | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>2-5-1969 |                                                                                     |                                              | 2b. HOUR<br>3:00 P.M. |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br>White | 5. DATE OF BIRTH<br>6-12-84                                                                      |                                                                                                                   | 6. AGE (In years last birthday)<br>85 yrs.                                                                                                                  |                  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                             |                    | IF UNDER 24 HRS.<br>HOURS MIN.                                        |                                                       | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>February 5, 1969                      |                                              | 2d. HOUR<br>3:00 P.M. |
| 7a. BIRTHPLACE (State or foreign country)<br>allen, Md.                                                                                                                                                                                                                                                                                                                                                                                            |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                           |                                                                                                                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH<br>BALTIMORE Md.                                                                        |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Baltimore County General Hospital |                                                                                                                                                             |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Retired Butcher |                    |                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employed    |                                                                                     |                                              |                       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.                                                                                                                                                                                                                                                                                                                                               |                  | 13b. COUNTY<br>CARROLL                                                                           |                                                                                                                   | 13c. CITY OR TOWN<br>Sykesville                                                                                                                             |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                    | 13e. STREET AND NUMBER<br>Oakland Mills Road                          |                                                       |                                                                                     |                                              |                       |
| 14. FATHER'S NAME<br>First Middle Last<br>Jackson Huffington                                                                                                                                                                                                                                                                                                                                                                                       |                  |                                                                                                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth Malone                                                 |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No                                                                                                                                                                                                                                                                                                                                                                        |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>217-05-6118                 |                                                                                                                   | 17. INFORMANT ADDRESS<br>Florence P. Huffington Box 66A Oakland Mills 21784                                                                                 |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia and pulmonary thromboemboli</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>Multiple blunt injuries</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                                     |                  |                                                                                                  |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                                 |                  |                                                                                                  |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |                                                                                                  |                                                                                                                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |                  |                                                                                                            |                    |                                                                       |                                                       | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |                       |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                     |                  | 21b. TIME OF INJURY Month, Day, Year<br>3:05 P.M. 1-22 19 69                                     |                                                                                                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Driver in auto accident                                                  |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Street Liberty & |                                                                                                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Marriottsville Rd. Baltimore Md.                                                            |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |                                                                                                  |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| ACTUAL SIGNATURE<br>Charles S. Springate                                                                                                                                                                                                                                                                                                                                                                                                           |                  | M.D.<br>Charles S. Springate, M.D.                                                               |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                       |                                                       | 22b. DATE SIGNED<br>February 6, 1969                                                |                                              |                       |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                             |                  | ADDRESS (Street, city, town, or county)                                                          |                                                                                                                   |                                                                                                                                                             |                  |                                                                                                            |                    |                                                                       |                                                       |                                                                                     |                                              |                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                |                  | 23b. DATE<br>Feb. 8, 1969                                                                        |                                                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge                                                                                                           |                  |                                                                                                            |                    | 23d. LOCATION (City or Town) (County) (State)<br>Pikesville, Maryland |                                                       |                                                                                     |                                              |                       |
| 24. FUNERAL DIRECTOR<br>Loring Byers Chapel 8728 Liberty Road 21133                                                                                                                                                                                                                                                                                                                                                                                |                  |                                                                                                  |                                                                                                                   | 25. RECEIVED BY REGISTRAR<br>FEB 10 1969                                                                                                                    |                  |                                                                                                            |                    | 25b. REGISTRAR'S SIGNATURE                                            |                                                       |                                                                                     |                                              |                       |



4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                    |  |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| 02036                                                                                                                                                                                                                                                                                                                                                                                               |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |                                                                                                                                                          |  | 02031                                                                                        |  |                                                         |  |
| 1. DECEASED-NAME (Type or print) <sup>First</sup> Esther <sup>Middle</sup> Fox <sup>Last</sup> Hughes                                                                                                                                                                                                                                                                                               |  |                                                                                                                    |  |                                                                                                                                                          |  | 2a. DATE OF DEATH 2 Month 10 Day 69 Year                                                     |  | 2b. HOUR 7:15 AM                                        |  |
| 3. SEX Female                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE White                                                                                                      |  | 5. DATE OF BIRTH 10-2-94 1895                                                                                                                            |  | 6. AGE (In years lost birthday) 73 YRS.                                                      |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH Baltimore Md.                                                             |  |                                                         |  |
| 10. CITY OR TOWN OF DEATH Randallstown                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co. Gen. Hosp.              |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) uk                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY uk                                                         |  |                                                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland                                                                                                                                                                                                                                                                                              |  | 13b. COUNTY Balto.                                                                                                 |  | 13c. CITY OR TOWN Balto.                                                                                                                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER 437 Yale Avenue                  |  |
| 14. FATHER'S NAME <sup>First</sup> Henry <sup>Middle</sup> ? <sup>Last</sup> Fox                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME <sup>First</sup> Pearl <sup>Middle</sup> ? <sup>Last</sup> Clark                          |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) No                                                                                     |  |                                                                                              |  |                                                         |  |
| 16b. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                            |  | 17. INFORMANT Mr. Henry C. Fox<br><del>Robert L. Fox</del> 5000 Cedar Ave. 21227                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS<br>4123 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE |  |                                                                                                                    |  |                                                                                                                                                          |  |                                                                                              |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                  |  |                                                                                                                    |  |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                                              |  |                                                         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                                              |  |                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                             |  |                                                                                                                    |  |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 22b. SIGNATURE J. Hubbard, M.D.                                                                                                                                                                                                                                                                                                                                                                     |  | DEGREE                                                                                                             |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED 2-10-69                                                                     |  |                                                         |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS                                                                                                       |  |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE 2-12-1969                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery                                                                                                   |  | 23d. LOCATION (City or Town) (County) (State) Md. Glen Burnie, Anne Arundel Co.              |  |                                                         |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS                                                                                                            |  | 25a. REC'D BY REGISTRAR                                                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |                                                         |  |
| Howard H. Hubbard, 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                                                                                                |  | 21229                                                                                                              |  | DATE FEB 11 1969                                                                                                                                         |  | J. Charles Judge                                                                             |  |                                                         |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                             |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                    |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                     |  |                                                                                      | First<br>Jack                                                                                             |                                                                                                                                                             | Middle<br>NMI                                                            |                                                                                                        | Last<br>Hurtig                                                                                  |                                                                           | 2a. DATE OF DEATH<br>Month Day Year<br>02 27 69                 |                                                                    |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br>White                                                                     |                                                                                                           | 5. DATE OF BIRTH<br>3/3/1916                                                                                                                                |                                                                          |                                                                                                        | 6. AGE (In years<br>last birthday)<br>52 YRS.                                                   |                                                                           | 2b. HOUR<br>10:13 PM                                            |                                                                    |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>NEW YORK CITY                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                               |                                                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                          | 9. COUNTY OF DEATH<br>Baltimore                                                                        |                                                                                                 |                                                                           | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |                                                                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                  |  |                                                                                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. Cnty. Gen. Hosp |                                                                                                                                                             |                                                                          | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Salesman |                                                                                                 |                                                                           | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>PAPER PRODUCTS          |                                                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland                                                                                                                                                                                                                                            |  |                                                                                      | 13b. COUNTY<br>Balto.                                                                                     |                                                                                                                                                             | 13c. CITY OR TOWN<br>Balto.                                              |                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                           | 13e. STREET AND NUMBER<br>4113 Buckingham Rd.                   |                                                                    |  |
| 14. FATHER'S NAME<br>First Middle Last<br>ISIDORE HURTIG                                                                                                                                                                                                                                                                                                |  |                                                                                      | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>LIZZIE ?                                                 |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>NO                                                                                                                                                                                                                                       |  |                                                                                      | 16b. SOCIAL SECURITY NO.<br>064-10-7770                                                                   |                                                                                                                                                             | 17. INFORMANT<br>Address<br>MRS. SARA HURTIG, 4113 BUCKINGHAM RD. #21207 |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction, acute<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>30 MIN<br>5 YRS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                      |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 19a. DATE OF OPERATION<br>0                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>0                                |                                                                                                           |                                                                                                                                                             |                                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? 0 |                                                                 |                                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 09                           |                                                                                                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>0                                                                        |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)<br>0 |                                                                                                           | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>0                                                                                           |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-12-68, to 2-27-69, that (I) (we) last saw the deceased alive on 2-27-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                  |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 22b. SIGNATURE<br>H. Gerard Oster MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                             |  |                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                          |                                                                                                        |                                                                                                 | 22c. DATE SIGNED<br>2-27-69                                               |                                                                 |                                                                    |  |
| 22d. PHYSICIAN'S NAME (Type)<br>H. GERARD OSTER                                                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                                                           | 22e. ADDRESS<br>6821 Reisterstown Rd Balto                                                                                                                  |                                                                          |                                                                                                        |                                                                                                 |                                                                           |                                                                 |                                                                    |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>3-2-69                                                                  |                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH EL MEMORIAL PARK                                                                                                 |                                                                          |                                                                                                        | 23d. LOCATION (City or Town) (County) (State)<br>RANDALLSTOWN, MARYLAND                         |                                                                           |                                                                 |                                                                    |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                         |  |                                                                                      |                                                                                                           | 25a. REC'D BY REGISTRAR<br>DATE<br>MAR 5 1969                                                                                                               |                                                                          | 25b. REGISTRAR'S SIGNATURE<br>Chambers                                                                 |                                                                                                 |                                                                           |                                                                 |                                                                    |  |

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                  |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 02038                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 02033                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                        | 2a. DATE OF DEATH                                                                       |                                                                      |                                                                                              | 2b. HOUR                                     |
| WILLIAM EDWIN ITZOE                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        | Month Day Year<br>2 - 11 - 69                                                           |                                                                      |                                                                                              | 5:00 P.                                      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                        |                                                                                         | 6. AGE (In years last birthday)                                      |                                                                                              | 7. IF UNDER 1 YEAR MONTHS DAYS               |
| MALE                                                                                                                                                                                                                                                                                                                                                                                         |  | WHITE                                                                        |                                                                              | 12-18-86                                                                                                                                                 |                                                                        |                                                                                         | 82 YRS.                                                              |                                                                                              |                                              |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                        | 9. COUNTY OF DEATH                                                                      |                                                                      |                                                                                              |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                    |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                          |                                                                        | Baltimore Md                                                                            |                                                                      |                                                                                              |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                              |
| Towson, Md.                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              | St. Joseph's Hospital                                                        |                                                                                                                                                          |                                                                        | Printer                                                                                 |                                                                      |                                                                                              |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                          |                                                                        | 13c. CITY OR TOWN                                                                       |                                                                      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        | Baltimore                                                                               |                                                                      |                                                                                              |                                              |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| Charles S. Itzoe                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              | Mary Martin                                                                  |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)                                                                                                                                                                                                                                       |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT Address                                                  |                                                                                         |                                                                      |                                                                                              |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              | 216-05-5960                                                                  |                                                                                                                                                          | Mrs. Agnes V. Bayne 4348 Sheldon Ave.                                  |                                                                                         |                                                                      |                                                                                              |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4124 Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACVD &amp; Pulmo. Emphysema</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                                              |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION Street or R.F.D. No.                                                                                                                       |                                                                        | City or Town                                                                            |                                                                      | County State                                                                                 |                                              |
| 22a. I certify that (1X) (this hospital) attended the deceased from <u>2-8-</u> , 19 <u>69</u> , to <u>2-11-</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>2-11</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                         |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 22b. SIGNATURE <u>Punzalan M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                          | 22c. DATE SIGNED <u>2-11-69</u>                                        |                                                                                         |                                                                      |                                                                                              |                                              |
| 22d. PHYSICIAN'S NAME (Type) <u>J. Punzalan, M.D.</u>                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          | 22e. ADDRESS <u>7620 York Road, Towson, Md. 21204</u>                  |                                                                                         |                                                                      |                                                                                              |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                        | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                      |                                                                                              |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                       |  | 2/15/69                                                                      |                                                                              | Parkwood Cemetery                                                                                                                                        |                                                                        | Parkville, Md.                                                                          |                                                                      |                                                                                              |                                              |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                          | 25a. REC'D BY REGISTRAR                                                |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                           |                                                                                              |                                              |
| Ullrich Funeral Home 4210 Belair Road.                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              |                                                                                                                                                          | DATE <u>FEB 14 1969</u>                                                |                                                                                         | <u>Alvin A. Under</u>                                                |                                                                                              |                                              |

02002

02002

CONFIDENTIAL  
RECEIVED & INDEXED  
JAN 10 1963

January 10 1963

FEB 1 1963

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02039

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02034

|                                                                                                                                     |         |                  |                                                                                                                                               |                 |      |                                                                                                                                                                                                      |      |                          |                                                                                   |                   |  |                                                                              |                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------|---------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------------------------|-----------------------------------------------------------------------------------|-------------------|--|------------------------------------------------------------------------------|---------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                 |         |                  | First Middle Last                                                                                                                             |                 |      | 2a. DATE KNOWN OF DEATH                                                                                                                                                                              |      |                          |                                                                                   | 2b. HOUR OF DEATH |  |                                                                              |                           |  |
| Otto Seigfred Jacobsen                                                                                                              |         |                  |                                                                                                                                               |                 |      | Month 2 Day 21 Year 69                                                                                                                                                                               |      |                          |                                                                                   | Hour 445 M        |  |                                                                              |                           |  |
| 3. SEX                                                                                                                              | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)                                                                                                               | IF UNDER 1 YEAR |      | IF UNDER 24 HRS.                                                                                                                                                                                     |      | 2c. DATE PRONOUNCED DEAD |                                                                                   |                   |  | 2d. HOUR                                                                     |                           |  |
| Male                                                                                                                                | White   | Dec 15, 1897     | 71 YRS.                                                                                                                                       | MONTHS          | DAYS | HOURS                                                                                                                                                                                                | MIN. | Month 2 Day 21 Year 69   |                                                                                   |                   |  | Hour 545 M                                                                   |                           |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                           |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                  |                 |      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                                                                                                |      |                          | 9. COUNTY OF DEATH                                                                |                   |  |                                                                              | 10. CITY OR TOWN OF DEATH |  |
| Denmark                                                                                                                             |         |                  | U.S.A.                                                                                                                                        |                 |      | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                   |      |                          | Baltimore                                                                         |                   |  |                                                                              | Essex                     |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                                        |         |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                       |                 |      | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                    |      |                          | 13a. INSIDE CITY LIMITS?                                                          |                   |  |                                                                              | 13b. STREET AND NUMBER    |  |
| 24 Holly Beach Ave                                                                                                                  |         |                  | Retired Machinist                                                                                                                             |                 |      |                                                                                                                                                                                                      |      |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                   |  |                                                                              | 24 Holly Beach Ave        |  |
| 13c. CITY OR TOWN                                                                                                                   |         |                  | 14. FATHER'S NAME                                                                                                                             |                 |      | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                             |      |                          | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                      |                   |  |                                                                              | 16b. SOCIAL SECURITY NO.  |  |
| Essex                                                                                                                               |         |                  | First Middle Last                                                                                                                             |                 |      | First Middle Last                                                                                                                                                                                    |      |                          | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW 1          |                   |  |                                                                              | 219-10-2672               |  |
| Maryland                                                                                                                            |         |                  | ? <del>Jack</del> Jacobsen                                                                                                                    |                 |      | ? ? ?                                                                                                                                                                                                |      |                          | Kathryn C Jacobsen                                                                |                   |  |                                                                              | Same                      |  |
| 17. INFORMANT                                                                                                                       |         |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4109               |                 |      | 19. DATE OF OPERATION                                                                                                                                                                                |      |                          | 20. AUTOPSY?                                                                      |                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |                           |  |
| ADDRESS                                                                                                                             |         |                  | Acute Coronary Occlus                                                                                                                         |                 |      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                    |      |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                   |  |                                                                              |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                      |         |                  | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                |                 |      | DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                       |      |                          | DUE TO, OR AS A CONSEQUENCE OF                                                    |                   |  |                                                                              |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) |         |                  |                                                                                                                                               |                 |      |                                                                                                                                                                                                      |      |                          |                                                                                   |                   |  |                                                                              |                           |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>                                   |         |                  | 21b. TIME OF INJURY Month, Day, Year                                                                                                          |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                      |      |                          | 21d. INJURY OCCURRED                                                              |                   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                           |  |
| CAUSE OF DEATH                                                                                                                      |         |                  | 19                                                                                                                                            |                 |      |                                                                                                                                                                                                      |      |                          | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                 |                           |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                      |         |                  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |                 |      | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |      |                          | 22b. DATE SIGNED                                                                  |                   |  | 22c. NAME OF CEMETERY OR CREMATORY                                           |                           |  |
| ACTUAL SIGNATURE                                                                                                                    |         |                  | Theodore C Patterson                                                                                                                          |                 |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                                                                      |      |                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                               |                   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                             |                           |  |
| EXAMINER'S NAME (Type)                                                                                                              |         |                  | Dr Theodore C Patterson                                                                                                                       |                 |      | ADDRESS                                                                                                                                                                                              |      |                          | 22d. LOCATION (City or Town) (County) (State)                                     |                   |  | 22e. REC'D BY REGISTRAR                                                      |                           |  |
| Burial                                                                                                                              |         |                  | 2/25/69                                                                                                                                       |                 |      | Baltimore National                                                                                                                                                                                   |      |                          | Baltimore, Maryland                                                               |                   |  | FEB 24 1969                                                                  |                           |  |
| 24. FUNERAL DIRECTOR                                                                                                                |         |                  | Leonard J Ruck Inc. Baltimore, Maryland                                                                                                       |                 |      | 25a. REGISTRAR'S SIGNATURE                                                                                                                                                                           |      |                          | 25b. REGISTRAR'S SIGNATURE                                                        |                   |  | Charles Judge                                                                |                           |  |

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02040

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02035

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                  |                                                                                                                                                                                                                                                                                 |                 |                  |                                                                                                                                                                 |  |  |                                                                                   |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                               |         |                  | First Middle Last                                                                                                                                                                                                                                                               |                 |                  | 2a. DATE KNOWN OF DEATH                                                                                                                                         |  |  | 2b. HOUR                                                                          |  |  |
| Harry L. Jenkins                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                  |                                                                                                                                                                                                                                                                                 |                 |                  | Month Day Year                                                                                                                                                  |  |  | 2:50 PM                                                                           |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)                                                                                                                                                                                                                                                 | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                                                                                                                                        |  |  | 2d. HOUR                                                                          |  |  |
| M                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Wh      | 11-11-89         | 79 YRS.                                                                                                                                                                                                                                                                         | MONTHS          | DAYS             | Month Day Year                                                                                                                                                  |  |  | 2:50 PM                                                                           |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                    |                 |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  |  | 9. COUNTY OF DEATH                                                                |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                  | U.S.A.                                                                                                                                                                                                                                                                          |                 |                  |                                                                                                                                                                 |  |  | Baltimore Md.                                                                     |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                                                                                                                                                                                    |                 |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                         |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |  |  |
| Balto.                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                  | Balto. Co. Gen. Hosp.                                                                                                                                                                                                                                                           |                 |                  | Auto Mechanic                                                                                                                                                   |  |  | Auto                                                                              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                                     |         |                  | 13b. COUNTY                                                                                                                                                                                                                                                                     |                 |                  | 13c. CITY OR TOWN                                                                                                                                               |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| MD.                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                  | Balto.                                                                                                                                                                                                                                                                          |                 |                  |                                                                                                                                                                 |  |  | 5531 Windsor Mill Rd.                                                             |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                                                                        |                 |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                                                              |  |  | 16b. SOCIAL SECURITY NO.                                                          |  |  |
| Jacob Jenkins                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  | Lenora Barnes                                                                                                                                                                                                                                                                   |                 |                  | no                                                                                                                                                              |  |  | 216-05-0686                                                                       |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                       |                 |                  | 19. DATE OF OPERATION                                                                                                                                           |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |  |  |
| Mrs. Vola H. Jenkins                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Punctured Wound to Head</u><br>955 X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                 |                  |                                                                                                                                                                 |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                               |         |                  |                                                                                                                                                                                                                                                                                 |                 |                  |                                                                                                                                                                 |  |  |                                                                                   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                  |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.<br>19                                                                                                                                                                                                                 |                 |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                 |  |  |                                                                                   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                            |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                                                                                                                                                                                    |                 |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                    |  |  |                                                                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  | 22b. DATE SIGNED                                                                                                                                                                                                                                                                |                 |                  | 22c. REGISTRAR'S SIGNATURE                                                                                                                                      |  |  |                                                                                   |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                        |         |                  | J. Nelson McKay M.D.                                                                                                                                                                                                                                                            |                 |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  | 22b. DATE SIGNED<br>2-12-69                                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |         |                  | 23b. DATE                                                                                                                                                                                                                                                                       |                 |                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                              |  |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                  | Feb. 15, 1969                                                                                                                                                                                                                                                                   |                 |                  | Lakeview Cemetery                                                                                                                                               |  |  | Sykesville Md.                                                                    |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                  | 25a. REC'D BY REGISTRAR                                                                                                                                                                                                                                                         |                 |                  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                      |  |  |                                                                                   |  |  |
| Loring Byers Chapel 8728 Liberty Road 21133                                                                                                                                                                                                                                                                                                                                                                                                       |         |                  | DATE FEB 17 1969                                                                                                                                                                                                                                                                |                 |                  | V. Charles J. J. J.                                                                                                                                             |  |  |                                                                                   |  |  |

00000

00000

RECEIVED

11-11-11

RECEIVED

RECEIVED

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

RECEIVED

RECEIVED

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                         |  |                                                                                                                                                          |                                      |                                                                                              |                         |                                                        |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|----------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                         |  |                                                                                                                                                          |                                      |                                                                                              |                         |                                                        |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                         |  |                                                                                                                                                          |                                      |                                                                                              |                         |                                                        |                                              |
| 1. DECEASED-NAME (Type or print) <b>Annie E. Johnson</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                         |  |                                                                                                                                                          | 2a. DATE OF DEATH <b>Feb 18 1969</b> |                                                                                              | 2b. HOUR <b>1:40 PM</b> |                                                        |                                              |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE <b>white</b>                                                                                    |  | 5. DATE OF BIRTH <b>Oct 14, 1886</b>                                                                                                                     |                                      | 6. AGE (In years lost birthday) <b>82</b> YRS.                                               |                         | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |                                              |
| 7a. BIRTHPLACE (State or foreign country) <b>Md</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. COUNTY OF DEATH <b>Baltimore</b> Md.                                                      |                         |                                                        |                                              |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Summit Nursing Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>                                                 |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                         |                                                        |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY <b>Baltimore</b>                                                                            |  | 13c. CITY OR TOWN <b>Woodlawn</b>                                                                                                                        |                                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                         | 13e. STREET AND NUMBER <b>6610 Dogwood Rd 21207</b>    |                                              |
| 14. FATHER'S NAME First <b>Charles</b> Middle <b>Depero</b> Last <b>Depero</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                         |  | 15. MOTHER'S MAIDEN NAME First <b>Catherine</b> Middle <b>Albright</b> Last <b>Albright</b>                                                              |                                      |                                                                                              |                         |                                                        |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)                                          |  | 17. INFORMANT <b>chart.</b>                                                                                                                              |                                      | Address                                                                                      |                         |                                                        |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA, RIGHT LOWER LOBE</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD; CVA, LEFT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATRIAL FIBRILLATIONS.</b> |  |                                                                                                         |  |                                                                                                                                                          |                                      |                                                                                              |                         |                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                          |  |                                                                                                         |  |                                                                                                                                                          |                                      |                                                                                              |                         |                                                        |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                         |                                                        |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                      |                                                                                              |                         |                                                        |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                      |                                                                                              |                         |                                                        |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/21, 1968</b> , to <b>2/18, 1969</b> , that (I) <del>was</del> last saw the deceased alive on <b>2/15, 1969</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) view the body after death.                                                                   |  |                                                                                                         |  |                                                                                                                                                          |                                      |                                                                                              |                         |                                                        |                                              |
| 22b. SIGNATURE <b>E. Kasaite, M.D.</b> DEGREE <b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                         |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |                                      | 22c. DATE SIGNED <b>2/18/69</b>                                                              |                         |                                                        |                                              |
| 22d. PHYSICIAN'S NAME (Type) <b>E. KASAITIS, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                         |  | 22e. ADDRESS <b>1801 FREDERICK RD BALTIMORE, MD 21228</b>                                                                                                |                                      |                                                                                              |                         |                                                        |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE <b>2-21-1969</b>                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>                                                                                                    |                                      | 23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Md.</b>                         |                         |                                                        |                                              |
| 24. FUNERAL DIRECTOR <b>G. Howard Strong</b> ADDRESS <b>3207 W. North Ave.,</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                         |  | 25a. REC'D BY REGISTRAR <b>FEB 21 1969</b> DATE                                                                                                          |                                      | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                |                         |                                                        |                                              |

Female  
M.B. 1924  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

1014 N.Y.C. 15  
1014 N.Y.C. 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02042

02037

|                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                               |                                                                    |                                                                                                                                                             |                                                         |                                                                                                 |  |                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EMMA C. JONES</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                               | 2a. DATE OF DEATH<br>2 Month 9 Day 1969                            |                                                                                                                                                             |                                                         | 2b. HOUR<br>3A-M                                                                                |  |                                                    |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>W</b>                                                                                           |                                                                    | 5. DATE OF BIRTH<br><b>Sept. 7, 1884</b>                                                                                                                    |                                                         | 6. AGE (In years<br>lost birthday)<br><b>84</b> YRS.                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN           |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                   |                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                         | 9. COUNTY OF DEATH<br><b>BALTIMORE Co.</b> Md.                                                  |  |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Summit Nursing Home</b> |                                                                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>housewife</b>                                              |                                                         | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>home</b>                                             |  |                                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Howard</b>                                                                                  |                                                                    | 13c. CITY OR TOWN<br><b>Savage</b>                                                                                                                          |                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>200 Washington St</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Welby J. Redmont</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                               | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Rae Lee Nalls</b> |                                                                                                                                                             |                                                         |                                                                                                 |  |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b> (If yes give word and dates of service)                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                               | 16b. SOCIAL SECURITY NO.                                           |                                                                                                                                                             | 17. INFORMANT<br><b>Mary Carter - Savage Md</b> Address |                                                                                                 |  |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>2001</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lymphosarcoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36-48 Hrs</b><br><b>2 years</b> |  |                                                                                                               |                                                                    |                                                                                                                                                             |                                                         |                                                                                                 |  |                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                    |  |                                                                                                               |                                                                    |                                                                                                                                                             |                                                         |                                                                                                 |  |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                              |                                                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                             |                                                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                         |                                                                                                 |  |                                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |                                                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                         |                                                                                                 |  |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/2/69</b> to <b>2/9/69</b> , that (I) <b>(we)</b> lost<br>saw the deceased alive on <b>2/9/69</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the<br>causes stated above, (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.                                                                                            |  |                                                                                                               |                                                                    |                                                                                                                                                             |                                                         |                                                                                                 |  |                                                    |  |
| 22b. SIGNATURE<br><b>Raymond D. Bahr MD</b> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>                                                                                                                                                                                                                                                  |  |                                                                                                               |                                                                    | 22c. DATE SIGNED<br><b>2/9/69</b>                                                                                                                           |                                                         |                                                                                                 |  |                                                    |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RAYMOND D. BAHR MD</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                               |                                                                    | 22e. ADDRESS<br><b>St. Agnes Hospital</b>                                                                                                                   |                                                         |                                                                                                 |  |                                                    |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE<br><b>2/2/69</b>                                                                                    |                                                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Savage Cem</b>                                                                                                     |                                                         | 23d. LOCATION (City or Town) (County) (State)<br><b>Savage Md</b>                               |  |                                                    |  |
| 24. FUNERAL DIRECTOR<br><b>Donaldson Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS<br><b>Baltimore</b>                                                                                   |                                                                    | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1969</b>                                                                                                               |                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>                                              |  |                                                    |  |

05090

05090

05090

05090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02043

CERTIFICATE OF DEATH

02038

|                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>FRED</b>                                                                                                                                                                                                                                                                                                                                                           |  | First Middle Last<br><b>JONES</b>                                                                         |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>4</b> Year <b>69</b>                                                                                             |  | 2b. HOUR<br><b>12:10 PM</b>                                                                  |                                                                                    |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>NEGRO</b>                                                                                   |  | 5. DATE OF BIRTH<br><b>3/25/97</b>                                                                                                                          |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.                                            |                                                                                    |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                             |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.                                           |                                                                                    |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PACKING HOUSE</b>                                    |                                                                                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                           |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                    |
| 13e. STREET AND NUMBER<br><b>1618 N. Bond Street</b>                                                                                                                                                                                                                                                                                                                                                      |  | 14. FATHER'S NAME First Middle Last<br><b>WILLIE JONES</b>                                                |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>FANNIE WALKER</b>                                                                                          |  |                                                                                              |                                                                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>YES</b>                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.<br><b>217 05 32 90A</b>                                                          |  | 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>                                                                                          |  | Address                                                                                      |                                                                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 MONTHS</b><br><b>15 YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS, PULMONARY EMPHYSEMA, ARTERIOSCLEROTIC OBLITERANS</b>                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |                                                                                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO AUTOPSY</b>       |                                                                                    |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |                                                                                    |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> ot work <input type="checkbox"/>                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                              |                                                                                    |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>12/12/68</b> , 19__, to <b>2/5/69</b> , 19__, that (1) (we) last saw the deceased alive on <b>2/5/69</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                              |                                                                                    |
| 22b. SIGNATURE<br><i>Peter V. Juvan</i>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>2/5/69</b>                                                            |                                                                                    |
| 22d. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>                                                                                                            |  |                                                                                              |                                                                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                |  | 23b. DATE<br><b>Feb 10 / 69</b>                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>                                                                                             |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                       |                                                                                    |
| 24. FUNERAL DIRECTOR<br><b>ELLIOTT FUNERAL HOME</b><br><b>1123 N. Caroline St. Balt. Md.</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |  | 25a. REC'D BY REGISTRAR<br><b>FEB 10 1969</b>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                           |                                                                                    |







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | LAST                                                                         |  | 2a. DATE OF DEATH                                                                                                                                           |  |                                                                                              | 2b. HOUR |                                      |  |                  |  |                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------|--------------------------------------|--|------------------|--|-----------------|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 3. SEX                                                                       |  | 4. RACE                                                                                                                                                     |  | 5. DATE OF BIRTH                                                                             |          | 6. AGE (In years last birthday)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS |  |
| Joseph J. Kalivoda                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | Male                                                                         |  | Cau.                                                                                                                                                        |  | 6-18-1914                                                                                    |          | 2<br>22<br>1969                      |  | 7:15A            |  |                 |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                                           |          |                                      |  |                  |  |                 |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | USA                                                                          |  |                                                                                                                                                             |  | Balto.                                                                                       |          |                                      |  | Md.              |  |                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |          |                                      |  |                  |  |                 |  |
| Hyde                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | Box 51 Bottom Rd.                                                            |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                                                                           |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | 13e. STREET AND NUMBER               |  |                  |  |                 |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | Balto.                                                                       |  | Hyde                                                                                                                                                        |  | X                                                                                            |          | Box 51, Bottom Rd.                   |  |                  |  |                 |  |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| Joseph Kalivoda                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.                                                     |  | 17. INFORMANT                                                                                                                                               |  | Address                                                                                      |          |                                      |  |                  |  |                 |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | 056-16-8439                                                                  |  | Wife                                                                                                                                                        |  | Same                                                                                         |          |                                      |  |                  |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary Occlusion                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | (b) Hypertensive Cardiovascular disease                                      |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF                                               |  | (c) Arteriosclerosis                                                                                                                                        |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |                                      |  |                  |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 22a. I certify that (I) ( <del>the deceased</del> ) attended the deceased from Oct. 9th, 1967, to Feb. 22, 1969, that (I) ( <del>the deceased</del> ) last saw the deceased alive on Feb. 6, 1969, and that in (my) ( <del>the deceased</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>the deceased</del> ) (did) ( <del>the deceased</del> ) view the body after death. |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | DEGREE                                                                       |  | ATTENDING PHYS. <input checked="" type="checkbox"/>                                                                                                         |  | MED. DIRECTOR <input type="checkbox"/>                                                       |          | STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED |  |                 |  |
| Henry L. McCorkle                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                              |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  | 2-22-1969        |  |                 |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 22e. ADDRESS                                                                 |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| Henry L. McCorkle, M.D.                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | Jarrettsville Pike, Phoenix, Md. 21131                                       |  |                                                                                                                                                             |  |                                                                                              |          |                                      |  |                  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |  | 23d. LOCATION (City or Town) (County) (State)                                                |          |                                      |  |                  |  |                 |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | 2-25-1969                                                                    |  | Druid Ridge Cemetery                                                                                                                                        |  | Baltimore, Maryland                                                                          |          |                                      |  |                  |  |                 |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 1000 York Rd.                                                                |  | 25a. REC'D BY REGISTRAR                                                                                                                                     |  | 25b. REGISTRAR'S SIGNATURE                                                                   |          |                                      |  |                  |  |                 |  |
| Wm. Cook-Brooks Towson, Inc. Towson, Md. 21204                                                                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                              |  | FEB 25 1969                                                                                                                                                 |  | Charles Judge                                                                                |          |                                      |  |                  |  |                 |  |

MEDICAL CERTIFICATION

02030

02030

02030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rejoin carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A19 (4)  
30M REV. 1-66

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                  |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|---------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                 |  |                                                                                                                  |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                  |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                         |  | First <u>CAROLINE</u>                                                                                            |  | Middle <u>F.</u>                                                                                                                                            |  | Last <u>KASAK</u>                                                                            |  | 2a. DATE OF DEATH<br>Feb Month 16 Day 1969 Year          |  | 2b. HOUR <u>6:45</u> AM                                       |  |
| 3. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><u>WHITE</u>                                                                                          |  | 5. DATE OF BIRTH<br><u>MAY 17 - 1896</u>                                                                                                                    |  | 6. AGE (In years lost birthday)<br><u>72</u> YRS.                                            |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____               |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>POLAND</u>                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>POLAND</u>                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>BALTIMORE COUNTY - Md.</u>                                          |  |                                                          |  |                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE COUNTY</u>                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>ST. JOSEPH'S NURSING HOME</u> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>HOUSE WIFE</u>                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>_____                                                   |  |                                                          |  |                                                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>                                                                                                                                                                                                                                                                    |  | 13b. COUNTY <u>HOWARD</u>                                                                                        |  | 13c. CITY OR TOWN<br><u>ELK RIDGE</u>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>6619 OLD WASHINGTON Rd.</u> |  |                                                               |  |
| 14. FATHER'S NAME First <u>LUDWIK</u> Middle _____ Last <u>KOZIOL</u>                                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME First <u>FRANCES</u> Middle _____ Last <u>MIRA</u>                                      |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br>_____                                                                                |  | 17. INFORMANT Address<br><u>JOSEPH KASAK - 6619 OLD WASHINGTON Rd.</u>                                                                                      |  |                                                                                              |  |                                                          |  |                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><u>4109</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.       |  |                                                                                                                  |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>sudden</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>_____                                                                                                                                                                                                                                 |  |                                                                                                                  |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                                          |  |                                                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year _____<br>P.M. _____ 19 _____                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                     |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                                                                        |  |                                                                                              |  |                                                          |  |                                                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>31 Jan., 1969</u> , to _____, 19____, that (I) (we) last saw the deceased alive on <u>15 Feb. 1969</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |                                                                                                                  |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| 22b. SIGNATURE<br><u>William Goodman</u>                                                                                                                                                                                                                                                                                                                                    |  | DEGREE _____                                                                                                     |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><u>Feb 16, 1969</u>                                                      |  |                                                          |  |                                                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>WILLIAM GOODMAN, M.D.</u>                                                                                                                                                                                                                                                                                                                |  | 22e. ADDRESS<br><u>1334 SULPHUR SPRING Rd - 21227.</u>                                                           |  |                                                                                                                                                             |  |                                                                                              |  |                                                          |  |                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><u>FEB. 20 - 1969</u>                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ST. STANISLAUS</u>                                                                                                 |  | 23d. LOCATION (City or Town)<br><u>BALTIMORE</u>                                             |  | (County) _____ (State) <u>Md.</u>                        |  |                                                               |  |
| 24. FUNERAL DIRECTOR<br><u>GEORGE A. WEBER - 705 S. Ann St. #21231</u>                                                                                                                                                                                                                                                                                                      |  | ADDRESS _____                                                                                                    |  | 25a. REC'D BY REGISTRAR<br><u>FEB 18 1969</u>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE _____                                                             |  |                                                          |  |                                                               |  |

MEDICAL CERTIFICATION

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

02000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                 |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                         |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                 |  |  | First<br>Arthur                                                                                       |  |  | Middle<br>nmi                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | Last<br>Katzenell                                                                           |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                      |  |  | 4. RACE<br>White                                                                                      |  |  | 5. DATE OF BIRTH<br>8-1-03                                                                                                                                                                                                                                                                                                                                                                                              |  |  | 2a. DATE OF DEATH<br>02 Month 06 Day 69 Year                                                |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTO., MD.                                                                                                                                                                                                                                            |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>MD. USA                                                               |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                             |  |  | 9. COUNTY OF DEATH<br>Baltimore                                                             |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                           |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Baltimore Co Gen Hosp |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>SALESMAN                                                                                                                                                                                                                                                                                                                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HESS SHOES                                             |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.                                                                                                                                                                                                |  |  | 13b. CITY OR TOWN<br>Balto                                                                            |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    |  |  | 13e. STREET AND NUMBER<br>3902 Hilton Rd. Apt 32                                            |  |  |
| 14. FATHER'S NAME<br>XXXXXXXXXX UNKNOWN                                                                                                                                                                                                                                                             |  |  | 15. MOTHER'S MAIDEN NAME<br>XXXX JENNIE                                                               |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO                                                                                                                                                                                                                                                                                                                                               |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                           |  |  |
| 17. INFORMANT<br>MRS. LENA KATZENELL                                                                                                                                                                                                                                                                |  |  | Address<br>3902 HILTON RD. #15                                                                        |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4121<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASC H - Coronary Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Severe arteriosclerosis</u> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Terminal<br>YRS<br>YRS                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                  |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                      |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>yes (PARTIAL AUTOP) |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                            |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                            |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                        |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                          |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                             |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-4-1969, to 2-6-1969, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |
| 22b. SIGNATURE<br>Simon Calle, MD                                                                                                                                                                                                                                                                   |  |  | DEGREE<br>PATHOLOGIST                                                                                 |  |  | 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                             |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Simon Calle, MD                                                                                                                                                                                                                                                     |  |  | 22e. ADDRESS<br>BALTIMORE COUNTY GENERAL HOSPITAL                                                     |  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                     |  |  | 23b. DATE<br>2-7-69                                                                         |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP                                                                                                                                                                                                                                             |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                                  |  |  | 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                                                                                                    |  |  | 25a. REC'D BY REGISTRAR<br>FEB 11 1969                                                      |  |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                          |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                             |  |  |

10000

33000

RECEIVED BY

RECEIVED BY

10000

10000

10000

RECEIVED BY

RECEIVED BY

RECEIVED BY

RECEIVED BY

RECEIVED BY

RECEIVED BY

RECEIVED BY

RECEIVED BY

RECEIVED BY



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------|--|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|-----------------------------------------------------------------------------------|------------------------------------------------|----------|----------------------------------------------------|--|--------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                             |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                     |  |  | First                                                                        |  | Middle   |                                                                                                                                                             | Last |  | 2a. DATE OF DEATH<br>Month Day Year                                               |                                                | 2b. HOUR |                                                    |  |                                |  |  |  |
| ABRAHAM                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | KIRSHNER                                                                     |  | FEBRUARY |                                                                                                                                                             | 11   |  | 1969                                                                              |                                                | 8:00A.M. |                                                    |  |                                |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 4. RACE                                                                      |  |          | 5. DATE OF BIRTH                                                                                                                                            |      |  | 6. AGE (In years last birthday)                                                   |                                                |          | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | WHITE                                                                        |  |          | AUGUST 5, 1912                                                                                                                                              |      |  | 56 YRS.                                                                           |                                                |          |                                                    |  |                                |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                               |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  |          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |  | 9. COUNTY OF DEATH                                                                |                                                |          |                                                    |  |                                |  |  |  |
| ALTOONA, PA.                                                                                                                                                                                                                                                                                                                                                                                            |  |  | U.S.A.                                                                       |  |          |                                                                                                                                                             |      |  | BALTIMORE                                                                         |                                                |          |                                                    |  |                                |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                               |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)                                                                      |      |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |                                                |          |                                                    |  |                                |  |  |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 7013 CONCORD ROAD                                                            |  |          | MANAGER                                                                                                                                                     |      |  | WHOLESALE FOODS                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                           |  |  | 13b. COUNTY                                                                  |  |          | 13c. CITY OR TOWN                                                                                                                                           |      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                |          | 13e. STREET AND NUMBER                             |  |                                |  |  |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                |  |  | BALTIMORE                                                                    |  |          |                                                                                                                                                             |      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                                |          | 7013 CONCORD ROAD                                  |  |                                |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 15. MOTHER'S MAIDEN NAME                                                     |  |          |                                                                                                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| HARRY                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | KIRSHNER                                                                     |  |          | REBECCA                                                                                                                                                     |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                |  |  | 16b. SOCIAL SECURITY NO.                                                     |  |          | 17. INFORMANT                                                                                                                                               |      |  | Address                                                                           |                                                |          |                                                    |  |                                |  |  |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 171-07-9115                                                                  |  |          | MRS. ESTHER KIRSHNER                                                                                                                                        |      |  | 7013 CONCORD ROAD                                                                 |                                                |          |                                                    |  |                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Rheumatic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |          |                                                    |  |                                |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                      |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                      |      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                                |          |                                                    |  |                                |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                      |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/10, 1967, to 2/11, 1969, that (I) (we) last saw the deceased alive on 12/12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                       |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   |                                                |          |                                                    |  |                                |  |  |  |
| 22b. SIGNATURE<br><u>Isadore Sborofsky M.D.</u>                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   | 22c. DATE SIGNED<br>2/11/69                    |          |                                                    |  |                                |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>ISADORE SBOROFSKY                                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   | 22e. ADDRESS<br>4734 PARK HEIGHTS AVENUE       |          |                                                    |  |                                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                               |  |  | 23b. DATE                                                                    |  |          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |      |  | 23d. LOCATION (City or Town) (County) (State)                                     |                                                |          |                                                    |  |                                |  |  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 2-12-69                                                                      |  |          | BNAI ISRAEL                                                                                                                                                 |      |  | BALTIMORE, MARYLAND                                                               |                                                |          |                                                    |  |                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                                                                         |  |  |                                                                              |  |          |                                                                                                                                                             |      |  |                                                                                   | 25a. REC'D BY REGISTRAR<br>DATE<br>FEB 13 1969 |          | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |                                |  |  |  |

12013

02057

DEPT. OF JUSTICE

RECEIVED  
JULY 10 1912  
KIRKPATRICK  
JULY 10 1912

WHITE  
JULY 10 1912

ALTONA, PA.  
U.S.A.

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

BALTIMORE  
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>02048</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02043</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>                                                                                                                                           |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------|-----------------------------|
| 1. DECEASED-NAME (Type or print) <b>JENNIE</b> First <b>REBECCA</b> Middle <b>KNITZ</b> Last                                                                                                                                                                                                                                                                                                                      |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       | 2a. DATE OF DEATH <b>2</b> Month <b>28</b> Day <b>69</b> Year                                            |                                                                                   |                                                                      | 2b. HOUR <b>8:20</b> AM                            |                                              |                             |
| 3. SEX <b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE <b>WHITE</b>                                                         |                                                                                                            | 5. DATE OF BIRTH                                                                                                                                         |                                       |                                                                                                          | 6. AGE (In years last birthday) <b>74</b> YRS.                                    |                                                                      | IF UNDER 1 YEAR MONTHS DAYS                        |                                              | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |                                                                                                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.                                                                  |                                                                                   |                                                                      |                                                    |                                              |                             |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GR. BLATO. MED. CENTER</b> |                                                                                                                                                          |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b> |                                                                                   |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>   |                                              |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                     |  |                                                                              | 13b. COUNTY <b>BALTIMORE</b>                                                                               |                                                                                                                                                          | 13c. CITY OR TOWN <b>RANDALLSTOWN</b> |                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER <b>3725 PIKESWOOD DRIVE</b> |                                              |                             |
| 14. FATHER'S NAME First <b>ISAAC</b> Middle <b>ROSENTHAL</b> Last                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                                                            | 15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle Last                                                                                                |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                  |  |                                                                              |                                                                                                            | 16b. SOCIAL SECURITY NO. <b>220-24-5988</b>                                                                                                              |                                       | 17. INFORMANT Address <b>MR. PHILIP KNITZ, 3725 PIKESWOOD DR. #21133</b>                                 |                                                                                   |                                                                      |                                                    |                                              |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>G.I. BLEEDING</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MASSIVE LIVER DAMAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>? CA. OF THE PANCREAS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                            |                                                                                                                                                          |                                       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |                                                                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                    |                                              |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.                  |                                                                                                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                            | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> , 19 <b>69</b> , to <b>2/28</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/28</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                 |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       |                                                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
| 22b. SIGNATURE <b>Mary O. Lin</b> M.D.-DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                                                     |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       | 22c. DATE SIGNED <b>2/28/69</b>                                                                          |                                                                                   |                                                                      |                                                    |                                              |                             |
| 22d. PHYSICIAN'S NAME (Type) <b>MARY O. LIN</b> MD.                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       | 22e. ADDRESS <b>GREATER BALTO. MED. CENTER</b>                                                           |                                                                                   |                                                                      |                                                    |                                              |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                           |  | 23b. DATE <b>2-28-69</b>                                                     |                                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY <b>MOSES MONTIFILORE</b>                                                                                              |                                       | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>                                 |                                                                                   |                                                                      |                                                    |                                              |                             |
| 24. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                            |                                                                                                                                                          |                                       | 25a. REC'D BY REGISTRAR DATE <b>MAR 3 1969</b>                                                           |                                                                                   | 25b. REGISTRAR'S SIGNATURE <b>William J. Vesper</b>                  |                                                    |                                              |                             |

7-10-1968

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 1. DECEASED NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | First Middle Last        |                                                                                                                                                             |                                                                                                                                        | 2a. DATE OF DEATH                             |                                                                                              | 2b. <del>AM</del> <b>PM</b>                  |                        |  |
| EDWARD JOHN KOCHER                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        | Month 2 Day 1 Year 69                         |                                                                                              | 2:05                                         |                        |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                      |                          | 5. DATE OF BIRTH                                                                                                                                            |                                                                                                                                        | 6. AGE (In years lost birthday)               |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS               |                        |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | CAUCASIAN                                                                    |                          | 10/16/17                                                                                                                                                    |                                                                                                                                        | 51 YRS.                                       |                                                                                              | IF UNDER 24 HRS<br>HOURS MIN                 |                        |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                          | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH                            |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY            |                        |  |
| Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | U. S. A.                                                                     |                          |                                                                                                                                                             |                                                                                                                                        | BALTIMORE CO.,                                |                                                                                              | Electric Co.                                 |                        |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |                                                                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY             |                                                                                              |                                              |                        |  |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | GREATER BALTO. MED. CENTER                                                   |                          | Set-Up Man western                                                                                                                                          |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                                |  |                                                                              | 13b. COUNTY              |                                                                                                                                                             | 13c. CITY OR TOWN                                                                                                                      |                                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                              | 13e. STREET AND NUMBER |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              | Baltimore                |                                                                                                                                                             | Dundalk                                                                                                                                |                                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                              | 6604 Marne Avenue      |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              | 15. MOTHER'S MAIDEN NAME |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              | First Middle Last        |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| Peter Kocher                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              | Mary Schleva             |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 16b. SOCIAL SECURITY NO. |                                                                                                                                                             | 17. INFORMANT (Wife) Address                                                                                                           |                                               |                                                                                              |                                              |                        |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              | 218-07-4254              |                                                                                                                                                             | Mrs. Ruth J. Kocher, 6604 Marne Ave.                                                                                                   |                                               |                                                                                              |                                              |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              | 3 MINUTES                                    |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HODGKINS DISEASE - WIDESPREAD</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              | 6 MONTHS                                     |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                           |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                   |                                               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                              |                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/31, 1969, to 2/1, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/1, 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |                                                                              |                          |                                                                                                                                                             |                                                                                                                                        |                                               |                                                                                              |                                              |                        |  |
| 22b. SIGNATURE<br><i>Barry R. Friedlander</i> M.D.                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                          |                                                                                                                                                             | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                               | 22c. DATE SIGNED<br>2/1/69                                                                   |                                              |                        |  |
| 22d. PHYSICIAN'S NAME (Type) BARRY R. FRIEDLANDER, M.D.                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |                          |                                                                                                                                                             | 22e. ADDRESS GREATER BALTO. MEDICAL CENTER                                                                                             |                                               |                                                                                              |                                              |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                    |                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                                                                        | 23d. LOCATION (City or Town) (County) (State) |                                                                                              |                                              |                        |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2/4/69                                                                       |                          | Oak Lawn Cemetery                                                                                                                                           |                                                                                                                                        | Baltimore, Maryland                           |                                                                                              |                                              |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                          |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br>DATE                                                                                                        |                                               | 25b. REGISTRAR'S SIGNATURE                                                                   |                                              |                        |  |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                          |                                                                                                                                                             | FEB 4 1969                                                                                                                             |                                               | <i>John J. Duda</i>                                                                          |                                              |                        |  |

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080

12080



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                          |                   |                                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                            |  |                                                                                                          |                   |                                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                          |                   |                                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Marie</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                          | First Middle Last |                                                                                                                                                                            |                                                                                      | 2a. DATE OF DEATH<br>Month Day Year <b>Feb. 7 1969</b>                                          |                                                                      | 2b. HOUR<br><b>7P.</b> M.                                        |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b>                                                                                  |                   | 5. DATE OF BIRTH<br><b>12-6-1894</b>                                                                                                                                       |                                                                                      | 6. AGE (In years last birthday)<br><b>74</b> YRS.                                               |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                               |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                |                                                                                      | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |                                                                      |                                                                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. 21210</b>                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2 Knoll Ridge Ct.</b> |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Secretary</b>                                                                |                                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Office</b>                                              |                                                                      |                                                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                            |  | 13b. COUNTY<br><b>Balto.</b>                                                                             |                   | 13c. CITY OR TOWN<br><b>Balto. 10</b>                                                                                                                                      |                                                                                      | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER<br><b>2 Knoll Ridge Ct.</b>               |  |
| 14. FATHER'S NAME First Middle Last<br><b>Henry A. Krausz</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                          |                   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth Schneider</b>                                                                                                   |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-9877A</b>                                                          |                   | 17. INFORMANT<br><b>Dorothy Krausz</b>                                                                                                                                     |                                                                                      | Address<br><b>Same</b>                                                                          |                                                                      |                                                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Colon</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                                                          |                   |                                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                     |  |                                                                                                          |                   |                                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                         |                   |                                                                                                                                                                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                               |                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                            |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |                   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                               |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 68</b> to <b>Feb 7 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 19 69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |                                                                                                          |                   |                                                                                                                                                                            |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 22b. SIGNATURE<br><b>W. G. Helffrich M.D.</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                                          |                   | DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                      | 22c. DATE SIGNED<br><b>2-8-69</b>                                                               |                                                                      |                                                                  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William G. Helffrich M.D.</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                          |                   | 22e. ADDRESS<br><b>5006 Roland Ave., Balto., Md.</b>                                                                                                                       |                                                                                      |                                                                                                 |                                                                      |                                                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>2-10-69</b>                                                                              |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                                                                                                                    |                                                                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |                                                                      |                                                                  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                                          |                   | ADDRESS<br><b>4905 York Rd., Balto.</b>                                                                                                                                    |                                                                                      | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 11 1969</b>                                              |                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |

222

19-255

1994

• 1990年12月21日

1

■ **Cost**

01/08/2005

• 222 •

1972

00000000000000000000000000000000

David S. Forster

• **Chlorophyll**

SECRET

[illegible]

subline 22

1000

4552

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02051

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02046

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                              |                                                                                                                 |  |                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>Carroll E. Krieger</b>                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                              | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>2/15/69</b> |                                                                                                                                                             |                                                                                              | 2b. HOUR <b>11:50 PM</b>                                                                                        |  |                                                     |
| 3. SEX <b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>April 17, 1911</b>                                       | 6. AGE (In years, month, day) <b>57 YRS</b>                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                            | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                                             | 2c. DATE PRONOUNCED DEAD<br>Month <b>2</b> Day <b>16</b> Year <b>1969</b>                                       |  |                                                     |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                            |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |                                                                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                              | 9. COUNTY OF DEATH <b>Baltimore Co.</b>                                                                         |  |                                                     |
| 10. CITY OR TOWN OF DEATH <b>Parkville, Md</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3054 Oak Forest Dr. 21234</b>                               |                                                                                                                                                             |                                                                                              | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Machinist-retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                             |                      |                                                                              | 13b. COUNTY <b>Balto.</b>                                                                                                                   | 13c. CITY OR TOWN <b>Parkville</b>                                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <b>3054 Oak Forest Dr. 21234.</b>                                                        |  |                                                     |
| 14. FATHER'S NAME First <b>Elmer</b> Middle <b>F.</b> Last <b>Krieger</b>                                                                                                                                                                                                                                                                                                                                                                            |                      |                                                                              | 15. MOTHER'S MAIDEN NAME First <b>Lula</b> Middle <b>Batzer</b> Last <b>Batzer</b>                                                          |                                                                                                                                                             |                                                                                              |                                                                                                                 |  |                                                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>                                                                                                                                                                                                                                                                                                                                                                         |                      |                                                                              | 16b. SOCIAL SECURITY NO. <b>0</b>                                                                                                           |                                                                                                                                                             | 17. INFORMANT ADDRESS <b>Mr. Edward N. Krieger, 7622 Mars Ave.</b>                           |                                                                                                                 |  |                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                          |                      |                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                              |                                                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                  |                      |                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                              |                                                                                                                 |  |                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                           |                                                                                                                                                             |                                                                                              | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                |  |                                                     |
| 21a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                               |                      |                                                                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.                                                                            |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |                                                                                                                 |  |                                                     |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                               |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                                                                                                                             |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |                                                                                                                 |  |                                                     |
| 22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Noturol causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> |                      |                                                                              |                                                                                                                                             |                                                                                                                                                             |                                                                                              |                                                                                                                 |  |                                                     |
| ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                                                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                             |                                                                                                                                                             |                                                                                              | 22b. DATE SIGNED <b>2/16/1969</b>                                                                               |  |                                                     |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                                                              | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                              |                                                                                                                                                             |                                                                                              | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                                                |  |                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                                                              | ADDRESS (Street, city, town, or county)                                                                                                     |                                                                                                                                                             |                                                                                              |                                                                                                                 |  |                                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                              |                      | 23b. DATE <b>2/19/69.</b>                                                    | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>                                                                                 |                                                                                                                                                             |                                                                                              | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>                                             |  |                                                     |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                                                              | ADDRESS <b>21214</b>                                                                                                                        |                                                                                                                                                             |                                                                                              | 25a. REC'D BY REGISTRAR <b>FEB 17, 1969</b>                                                                     |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>       |



02052

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02047

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                          |                        |                                                                                                                                                             |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                        |                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                        | First<br><b>Mary</b>                                                                                     | Middle<br><b>Alice</b> | Last<br><b>Leach</b>                                                                                                                                        | 2a. DATE KNOWN OF DEATH<br>MATED <input checked="" type="checkbox"/> 2 7 69             |                                                                                                                                                                                                                                                                                                                                                                        | 2b. HOUR<br>10:00 P.M.                            |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>Cau.</b> | 5. DATE OF BIRTH<br><b>4-8, 1896</b>                                                                     |                        | 6. AGE (In years and birthday)<br><b>72</b> YRS.                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS                                                          | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                                                                                                                                                                                                                                                         | 2c. DATE PRONOUNCED DEAD<br>Month 2 Day 7 Year 69 |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                            |                        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                 |                                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2740 Moorgate Rd.</b> |                        |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life? even if retired.) |                                                                                                                                                                                                                                                                                                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>3</b>     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                        | 13b. COUNTY<br><b>Balto.</b>                                                                             |                        | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                        |                                                   |
| 13e. STREET AND NUMBER<br><b>2740 Moorgate Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                        | 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Baker</b> Last <b>Therese</b>                           |                        | 15. MOTHER'S MAIDEN NAME<br>First <b>Therese</b> Middle <b>Therese</b> Last <b>Therese</b>                                                                  |                                                                                         | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or no known)<br><b>No</b>                                                                                                                                                                                                                                                                                    |                                                   |
| 16b. SOCIAL SECURITY NO.<br><b>218-104-749</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                        | 17. INFORMANT<br><b>Mr/ Charles Waltz</b>                                                                |                        | ADDRESS<br><b>Same</b>                                                                                                                                      |                                                                                         | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>A-S-C-U Disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                        |                                                                                                          |                        |                                                                                                                                                             |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                        |                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>None</b>                                         |                        |                                                                                                                                                             |                                                                                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |                                                   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                        | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.<br><b>19</b>                                   |                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                        |                                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                        | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |                        | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                                         | City or Town County State                                                                                                                                                                                                                                                                                                                                              |                                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>22b. DATE SIGNED <b>2/9/69</b><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town or county)<br><b>M.B. Davis MD - Sunbury, Md</b> |                        |                                                                                                          |                        |                                                                                                                                                             |                                                                                         |                                                                                                                                                                                                                                                                                                                                                                        |                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                        | 23b. DATE<br><b>Feb. 12, 1969</b>                                                                        |                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>                                                                                    |                                                                                         | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                            |                                                   |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                        |                                                                                                          |                        | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 10 1969</b>                                                                                                          |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Walter</b>                                                                                                                                                                                                                                                                                                                    |                                                   |

03025

03025

NAME: [illegible] ADDRESS: [illegible] CITY: [illegible] STATE: [illegible] ZIP: [illegible]

DATE: [illegible] TIME: [illegible] FROM: [illegible] TO: [illegible]

REMARKS: [illegible]

INITIALS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

FROM: [illegible]

TO: [illegible]

REMARKS: [illegible]

INITIALS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

FROM: [illegible]

TO: [illegible]

REMARKS: [illegible]

INITIALS: [illegible]

SIGNATURE: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA AIS  
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02053

02048

|                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          |                                              |  |                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------|----------|----------------------------------------------|--|-------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                  |  | First                                                                        | Middle | Last                                                                                                                                                                | 2a. DATE OF DEATH |                                                                                              | 2b. HOUR |                                              |  |                   |  |
| MARK ANDREW LEVA                                                                                                                                                                                                                                                                                                                     |  |                                                                              |        |                                                                                                                                                                     | FEBRUARY 19, 1969 |                                                                                              | 5:30 M   |                                              |  |                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                      |        | 5. DATE OF BIRTH                                                                                                                                                    |                   | 6. AGE (In years lost birthday)                                                              |          | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS.  |  |
| MALE                                                                                                                                                                                                                                                                                                                                 |  | WHITE                                                                        |        | JULY 25, 1967                                                                                                                                                       |                   | 1 1/2 YRS.                                                                                   |          | MONTHS                                       |  | DAYS              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH                                                                           |          | Md.                                          |  |                   |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                             |  | U.S.A.                                                                       |        |                                                                                                                                                                     |                   | BALTIMORE,                                                                                   |          |                                              |  |                   |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)                                                                              |                   | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |          |                                              |  |                   |  |
| TOWSON                                                                                                                                                                                                                                                                                                                               |  | ST. JOSEPH HOSPITAL                                                          |        | CHILD (None)                                                                                                                                                        |                   |                                                                                              |          |                                              |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                  |        | 13c. CITY OR TOWN                                                                                                                                                   |                   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | 13e. STREET AND NUMBER                       |  |                   |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                             |  | BALTIMORE                                                                    |        | Baltimore                                                                                                                                                           |                   |                                                                                              |          | 10 VENUS COURT #21234                        |  |                   |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                    |  | First                                                                        |        | Middle                                                                                                                                                              |                   | Last                                                                                         |          | 15. MOTHER'S MAIDEN NAME                     |  | First Middle Last |  |
| Paul S. Leva                                                                                                                                                                                                                                                                                                                         |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          | Shelbie Graley                               |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown                                                                                                                                                                                                                                                                     |  | (If yes give war or dates of service)                                        |        | 16b. SOCIAL SECURITY NO.                                                                                                                                            |                   | 17. INFORMANT                                                                                |          | Address                                      |  |                   |  |
| No                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |        | None                                                                                                                                                                |                   | Mr. Paul S. Leva                                                                             |          | (Same)                                       |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                            |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diffuse encephalopathy</u><br><u>781.7</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                    |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          |                                              |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                   |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          |                                              |  |                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |                                              |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                                                                     |                   |                                                                                              |          |                                              |  |                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                        |                   |                                                                                              |          |                                              |  |                   |  |
|                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          |                                              |  |                   |  |
| 22a. I certify that (A) (this hospital) attended the deceased from February 17, 1969, to February 19, 1969, that (A) (we) last saw the deceased alive on February 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |        |                                                                                                                                                                     |                   |                                                                                              |          |                                              |  |                   |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                       |  | 22c. DATE SIGNED                                                             |        | 22d. PHYSICIAN'S NAME (Type)                                                                                                                                        |                   | 22e. ADDRESS                                                                                 |          |                                              |  |                   |  |
|                                                                                                                                                                                                                                                                                                                                      |  | February 19, 1969                                                            |        | Reynaldo Orjuela-Gomez, M.D.                                                                                                                                        |                   | 7620 York Road, Towson, Md. 21204                                                            |          |                                              |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                    |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                  |                   | 23d. LOCATION (City or Town) (County) (State)                                                |          |                                              |  |                   |  |
| Burial                                                                                                                                                                                                                                                                                                                               |  | 2/21/69.                                                                     |        | Gardens of Faith Cemetery                                                                                                                                           |                   | Baltimore, Md.                                                                               |          |                                              |  |                   |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                 |  | ADDRESS                                                                      |        | 25a. REC'D BY REGISTRAR                                                                                                                                             |                   | 25b. REGISTRAR'S SIGNATURE                                                                   |          |                                              |  |                   |  |
| Leonard J. Ruck, Inc. Balto. Md.                                                                                                                                                                                                                                                                                                     |  | 2 1214                                                                       |        | FEB 20 1969                                                                                                                                                         |                   |                                                                                              |          |                                              |  |                   |  |

3008

ESTIMATE OF LOSS

02022

FEB 20 1953

1953

1953

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                         |                                                 |                                                                                                             |                                                                                                                                                             |                                                        |                                                                                                                              |                                                       |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>Thomas A. Libershal</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                 | 2a. DATE KNOWN OF DEATH<br>Month <b>11</b> Year <b>1969</b>                                                 |                                                                                                                                                             |                                                        | 2b. HOUR OF DEATH<br><b>1:15</b> M                                                                                           |                                                       |                                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>June 28, 1948</b>        | 6. AGE (in years last birthday)<br><b>20</b> YRS                                                            | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>                                                                                                                       | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b> | 2c. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>11</b> Year <b>1969</b>                                                   |                                                       |                                              |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Nebraska</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |                                                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                        | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                                   |                                                       |                                              |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>8143 Gray Haven Road</b> |                                                                                                                                                             |                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Student - University of Md.</b> |                                                       | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                   |                         |                                                 | 13b. COUNTY <b>Baltimore</b>                                                                                |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Dundalk</b>                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              | 13e. STREET AND NUMBER<br><b>8143 Gray Haven Road</b> |                                              |
| 14. FATHER'S NAME<br>First <b>Theodore</b> Middle <b>M.</b> Last <b>Libershal</b>                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                 | 15. MOTHER'S MAIDEN NAME<br>First <b>Bertha</b> Middle <b>M.</b> Last <b>Jensen</b>                         |                                                                                                                                                             |                                                        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>                                              |                                                       |                                              |
| 16b. SOCIAL SECURITY NO.<br><b>215-52-2802</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                 | 17. INFORMANT (Mother)<br><b>Mrs. Bertha M. Libershal</b>                                                   |                                                                                                                                                             |                                                        | ADDRESS <b>Dundalk, Md.</b><br><b>8143 Gray Haven Rd.</b>                                                                    |                                                       |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>STRANGULATION by HANGING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>953X</b>                                                                                                |                         |                                                 |                                                                                                             |                                                                                                                                                             |                                                        |                                                                                                                              |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b>                                                                                                                                                                                                                                                                                                               |                         |                                                 |                                                                                                             |                                                                                                                                                             |                                                        |                                                                                                                              |                                                       |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                          |                         |                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |                                                                                                                                                             |                                                        | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                     |                                                       |                                              |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                  |                         |                                                 | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>2-11</b> P.M. <b>1969</b>                              |                                                                                                                                                             |                                                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)<br><b>Hungry in cell for 48 hrs</b>          |                                                       |                                              |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                               |                         |                                                 | 21e. PLACE OF INJURY (Home, farm, street, factory, office building, etc.)<br><b>Home</b>                    |                                                                                                                                                             |                                                        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>8143 Gray Haven Road Dundalk Md</b>                       |                                                       |                                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |                                                 |                                                                                                             |                                                                                                                                                             |                                                        |                                                                                                                              |                                                       |                                              |
| ACTUAL SIGNATURE<br><b>M.B. Davis</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                         |                                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                             |                                                                                                                                                             |                                                        | 22b. DATE SIGNED <b>2/12/69</b>                                                                                              |                                                       |                                              |
| EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                         |                                                                                                                                                             |                                                        | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                  |                                                       |                                              |
| M.D. ADDRESS (Street, city, town, or county) <b>M.D. Dundalk, Md. 21222</b>                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                 | 8800 Morningside Rd.                                                                                        |                                                                                                                                                             |                                                        |                                                                                                                              |                                                       |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                 | 23b. DATE<br><b>2/17/69</b>                                                                                 |                                                                                                                                                             |                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>                                                         |                                                       |                                              |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                 | 23e. REC'D BY REGISTRAR<br><b>FEB 17 1969</b>                                                               |                                                                                                                                                             |                                                        | 23f. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                             |                                                       |                                              |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                         |                                                 | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>                                                               |                                                                                                                                                             |                                                        |                                                                                                                              |                                                       |                                              |

THE STATE  
DEPT. OF HEALTH

02054

MEANS EXAMINATION CERTIFICATE OF DEATH

02054

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible] CITY: [illegible] COUNTY: [illegible] STATE: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE OF SIGNATURE: [illegible]

PLACE OF SIGNATURE: [illegible]

REMARKS: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02055

02050

|                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                             |                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND                                                                                                                                                                                                                                                                                             |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                     |                                                                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington, Baltio.</b>                                                                                                                                                                                                                                       |                                                                                                           | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>                                                                                                                  |                                                                                   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 9, Md.</b>                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>6733 Broadview Rd.</b>                                                                                                                                                                                                                                            |                                                                                                           | d. STREET ADDRESS<br><b>6733 Broadview Road</b>                                                                                                             |                                                                                   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Julia M. Lochte</b>                                                                                                                                                                                                                                                                                     |                                                                                                           | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>13</b> Year <b>19 69</b>                                                                                   |                                                                                   |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                              | 6. COLOR OR RACE<br><b>White</b>                                                                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 15 1886</b>                                           |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.                                                                                                                                                                                                                                                                                                    |                                                                                                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housekeeping own home</b>                                  |                                                                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Md.</b>                                                                                                                                                                                                                                                                     |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                               |                                                                                   |
| 13. FATHER'S NAME<br><b>Frank J. Lochte</b>                                                                                                                                                                                                                                                                                                          |                                                                                                           | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>                                                                                                                  |                                                                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No None</b>                                                                                                                                                                                                                            |                                                                                                           | 16. SOCIAL SECURITY NO.<br><b>unknown</b>                                                                                                                   |                                                                                   |
| 17. INFORMANT<br><b>Mr. Joseph Lochte, 6733 Broadview Rd.,</b>                                                                                                                                                                                                                                                                                       |                                                                                                           | Address <b>Baltimore 9, Md.</b>                                                                                                                             |                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Plutastic Carcinoma of</b><br>DUE TO <b>Stomach</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Carcinoma of Stomach</b><br>(c) <b>1 1/2 yrs</b> |                                                                                                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 yrs</b>                                                                                                        |                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                     |                                                                                                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                      |                                                                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                   |                                                                                                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>                                                                                                                                                                                                                                                                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      | 20f. (City or town) (County) (State)                                              |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>61</b> , to <b>Feb</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/10</b> , 19 <b>69</b> , and that death occurred at <b>5:00 PM</b> , from causes and on the date stated above.                                                         |                                                                                                           |                                                                                                                                                             |                                                                                   |
| 22a. SIGNATURE<br><b>Francis T. Daly, M.D.</b>                                                                                                                                                                                                                                                                                                       |                                                                                                           | 22b. DATE SIGNED<br><b>2/14/69</b>                                                                                                                          |                                                                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Francis T. Daly, M.D.</b>                                                                                                                                                                                                                                                                                         |                                                                                                           | 22d. ADDRESS<br><b>11 E. Chase Street</b>                                                                                                                   |                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                           | 23b. DATE THEREOF<br><b>Feb. 15, 1969</b>                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                                                                                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Frank H. Newell, Pikesville, Md.</b>                                                                                                                                                                                                                                                                                      |                                                                                                           | 25a. REC'D BY REGISTRAR<br><b>FEB 19 1969</b>                                                                                                               |                                                                                   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                                   |

03050

EXTRACTS OF DEEDS

03050

1880

1880

1880

1880

1880

1880

1880

1880

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02051

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                              |                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)<br><b>HELEN R. LOCKWOOD</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  | First Middle Last                                                                                     |  | 20. DATE OF DEATH<br>Feb 20 1969<br>Month Day Year                                                                                                          |  | 2b. HOUR<br>6:30 PM                                                                          |                                                          |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>W</b>                                                                                   |  | 5. DATE OF BIRTH<br><b>June 1 1910</b>                                                                                                                      |  | 6. AGE (In years last birthday)<br><b>58</b> YRS.                                            |                                                          |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penn</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto</b> Md.                                                       |                                                          |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3016 Third Ave</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>At home</b>                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                                          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY<br><b>Balto</b>                                                                           |  | 13c. CITY OR TOWN<br><b>Parkville</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                          |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas Rowan</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Julia Hullihan</b>                                   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>No</b>                                         |  |                                                                                              |                                                          |
| 16b. SOCIAL SECURITY NO.<br><b>213-12-4965</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 17. INFORMANT Address<br><b>Family records</b>                                                        |  |                                                                                                                                                             |  |                                                                                              |                                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>? cardiac arrhythmia</b><br><b>3940</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Rheumatic heart disease, mitral stenosis 20 years</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Styral phellotum, chronic cystitis, fracture</b> |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>circulation of liver, post necrotic</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                              |                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                      |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>              |                                                          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |                                                          |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                              |                                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <b>59</b> to <b>Feb</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3rd</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                               |  |                                                                                                       |  |                                                                                                                                                             |  |                                                                                              |                                                          |
| 22b. SIGNATURE<br><b>Abraham Benicini</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                       |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>2/21/69</b>                                                           |                                                          |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Abraham Genecin M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                       |  | 22e. ADDRESS<br><b>611 Park ave.</b>                                                                                                                        |  |                                                                                              |                                                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>2/24/69</b>                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>                                                                                                  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Md.</b>                    |                                                          |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>C.F. EVANS &amp; SON 8802 Harford road</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                       |  | 25a. REC'D BY REGISTRAR<br>DATE <b>24 1969</b>                                                                                                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                             |                                                          |

12821

12821

WILLIAM P. LUCKWOOD

June 1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940



1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02057

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02052

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                         |                                                                                                         |                                                  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                               |                                   |                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(Type or Print) <i>Joseph</i>                                                                                                                                                                                                                                                                                                                                                                                                 |                         | First <i>Joseph</i>                                                                                     |                                                  | Middle <i>H.</i>                                                                                                                                            |  | Last <i>Logue</i>                                                                                           |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <i>Feb. 17, 1969</i> |                                   | 2b. HOUR<br><i>12:15 a.m.</i>                                |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br><i>Nov. 29, 1903</i>                                                                | 6. AGE (in years and birthday)<br><i>65</i> YRS. | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____                                                                                                                  |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                                                                  |  | 2c. DATE PRONOUNCED DEAD<br><i>Feb. 17, 1969</i>                                              |                                   | 2d. HOUR<br><i>12:15 a.m.</i>                                |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                              |                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i>                                                                      |  |                                                                                               |                                   |                                                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>                                                                                                                                                                                                                                                                                                                                                                                                  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Westminster Road</i> |                                                  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Machinist</i> |  |                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY |                                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                       |                         | 13b. COUNTY<br><i>Balto.</i>                                                                            |                                                  | 13c. CITY OR TOWN<br><i>Woodlawn</i>                                                                                                                        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  | 13e. STREET AND NUMBER<br><i>2012 Russell Ave.</i>                                            |                                   |                                                              |  |
| 14. FATHER'S NAME<br><i>Francis A. Logue</i>                                                                                                                                                                                                                                                                                                                                                                                                      |                         | First <i>Francis</i>                                                                                    |                                                  | Middle <i>A.</i>                                                                                                                                            |  | Last <i>Logue</i>                                                                                           |  | 15. MOTHER'S MAIDEN NAME<br><i>Cleavie E. Frank</i>                                           |                                   | First <i>Cleavie</i>                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>No</i>                                                                                                                                                                                                                                                                                                                                                                |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><i>166-12-6945</i>                 |                                                  | 17. INFORMANT<br><i>Mrs. Norma A. Harmon</i>                                                                                                                |  |                                                                                                             |  | ADDRESS<br><i>Catonsville, Md.</i>                                                            |                                   |                                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hypertensive Arteriosclerotic C-V Disease</i><br><i>4122</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                   |                         |                                                                                                         |                                                  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                               |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mo.</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                               |                         |                                                                                                         |                                                  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                               |                                   |                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |                         |                                                                                                         |                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |  |                                                                                                             |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                   |                                                              |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH <i>none</i>                                                                                                                                                                                                                                                                                                                   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <i>19</i>                                  |                                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                             |  |                                                                                               |                                   |                                                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><i>none</i>             |                                                  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                                                                        |  |                                                                                                             |  |                                                                                               |                                   |                                                              |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |                                                                                                         |                                                  |                                                                                                                                                             |  |                                                                                                             |  |                                                                                               |                                   |                                                              |  |
| ACTUAL SIGNATURE <i>D. D. Caples</i>                                                                                                                                                                                                                                                                                                                                                                                                              |                         |                                                                                                         |                                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                             |  |                                                                                                             |  | 22b. DATE SIGNED <i>2-17-69</i>                                                               |                                   |                                                              |  |
| EXAMINER'S NAME (Type) <i>D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md.</i>                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                         |                                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                 |  |                                                                                                             |  |                                                                                               |                                   |                                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                        |                         | 23b. DATE<br><i>Feb. 20, 69</i>                                                                         |                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Park</i>                                                                                               |  |                                                                                                             |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Howard Co. Md.</i>                        |                                   |                                                              |  |
| 24. FUNERAL DIRECTOR<br><i>Hubbard Funeral Home 4107 Wilkens Ave. Balto.</i>                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                         |                                                  | ADDRESS<br><i>BALTO.</i>                                                                                                                                    |  |                                                                                                             |  | 25a. REC'D BY REGISTRAR<br><i>FEB 20 1969</i>                                                 |                                   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>           |  |

03083

03083

11.

7.

03083

03083

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>1</div> <div>02058</div> <div>02053</div>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                            |  |                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last<br><b>MICHAEL J LOSKARN JR</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                             |  |                                                                                                        |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year<br><b>2 16 1969</b>                                                            |  | 2b. HOUR<br><b>2:50 AM</b>                                                                                 |  |                                                         |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>W</b>                                                                         |  | 5. DATE OF BIRTH<br><b>Jan. 4, 1951</b>                                                                |  | 6. AGE (in years last birthday) MONTHS DAYS HOURS MIN.<br><b>18 YRS.</b>                                                                                 |  | 7c. DATE PRONOUNCED DEAD Month Day Year<br><b>2 16 1969</b>                                                |  | 2d. HOUR<br><b>3:00 AM</b>                              |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                 |  |                                                         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. County</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                             |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1010 Harwall Rd</b> |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Student-</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>St. Josephs</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                             |  | 13b. COUNTY <b>Balto Co.</b>                                                                           |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 13e. STREET AND NUMBER<br><b>1010 Harwall Rd 21207</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Michael J. Loskarn, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                             |  |                                                                                                        |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Marie Dolores Franz</b>                                                                                 |  |                                                                                                            |  |                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                             |  | 16b. SOCIAL SECURITY NO. (If give war or dates of service)                                             |  | 17. INFORMANT <b>1010 Harwall Rd. Michael J. Loskarn, Sr., 21207</b>                                                                                     |  |                                                                                                            |  |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>9139<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                |  |                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                            |  |                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |  |                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                            |  |                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                      |  |                                                                                                                                                          |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |                                                         |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                            |  |                                                                                             |  | 21b. TIME OF INJURY Month, Day, Year<br><b>2 16 19 69 2:50 P.M.</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18)<br><b>Plaster cast containing 3 bone pulled off heel</b>                 |  |                                                                                                            |  |                                                         |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b> |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>1010 HARWALL RD BALTO 21207</b>     |  |                                                                                                                                                          |  |                                                                                                            |  |                                                         |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                             |  |                                                                                                        |  |                                                                                                                                                          |  |                                                                                                            |  |                                                         |  |
| ACTUAL SIGNATURE <b>Werner R. U. Spitz</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                             |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                   |  |                                                                                                                                                          |  | 22b. DATE SIGNED <b>2 16 69</b>                                                                            |  |                                                         |  |
| EXAMINER'S NAME (Type) <b>WERNER R. U. SPITZ</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                                       |  |                                                                                                                                                          |  | ADDRESS (Street, city, town, or county)                                                                    |  |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>2-19-69</b>                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                                               |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                                                                              |  |                                                                                                            |  |                                                         |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke, 4101 Edmondson Ave, Balto., Md.</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                             |  | 25a. REC'D BY REGISTRAR<br><b>FEB 18 1969</b>                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                                                                                       |  |                                                                                                            |  |                                                         |  |



HEALTH UNIT

2002

GENERAL EXAMINATION & CERTIFICATE OF DEATH

00000

12

Albino

United States

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.

James A. Jackson, Jr.



**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| <div style="display: flex; justify-content: space-between;"> <span>02059</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02054</span> </div> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>                                                                                                            |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                                                        |  |                                                                      |                                   |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                            |  |                                                                                            |  | First Middle Last                                                                                                                                           |  |                                                                                                                                        |  | 2a. DATE OF DEATH<br>Month Day Year                                  |                                   | 2b. HOUR<br>6:30 M                           |  |
| Alphonse                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                            |  | Ludwig                                                                                                                                                      |  |                                                                                                                                        |  | 2-21-69                                                              |                                   |                                              |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br>Caucasian                                                                       |  | 5. DATE OF BIRTH<br>8-12-07                                                                                                                                 |  | 6. AGE (In years last birthday)<br>61 YRS.                                                                                             |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |                                   | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Balto.                                                                                                           |  |                                                                      |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Bartender Ret.                              |  |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br>—                                                                           |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                        |  | 13e. STREET AND NUMBER<br>3700 Ridgcroft Rd.                         |                                   |                                              |  |
| 14. FATHER'S NAME First Middle Last<br>Anton Ludwig                                                                                                                                                                                                                                                                                                            |  |                                                                                            |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Anna Unknown                                                                                                  |  |                                                                                                                                        |  |                                                                      |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br>212-01-8212                                                    |  | 17. INFORMANT Address<br>Anna Ludwig, 3700 Ridgcroft Rd.                                                                                                    |  |                                                                                                                                        |  |                                                                      |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                                                        |  |                                                                      |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Diabetes Mellitus</u>                                                                                                                                                                                                 |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                                                        |  |                                                                      |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                           |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                              |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                                                        |  |                                                                      |                                   |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)               |  | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |  | City or Town                                                                                                                           |  | County                                                               |                                   | State                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-26</u> , 19 <u>62</u> , to <u>2-8</u> , 19 <u>64</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |                                                                                            |  |                                                                                                                                                             |  |                                                                                                                                        |  |                                                                      |                                   |                                              |  |
| 22b. SIGNATURE<br><u>Sebastian Russo</u>                                                                                                                                                                                                                                                                                                                       |  |                                                                                            |  |                                                                                                                                                             |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>8-30 PM                                          |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Sebastian Russo, M.D.                                                                                                                                                                                                                                                                                                          |  |                                                                                            |  |                                                                                                                                                             |  | 22e. ADDRESS<br>5017 Harford Rd.                                                                                                       |  |                                                                      |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br>2-25-69                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gdns. of Faith                                                                                                        |  | 23d. LOCATION (City or Town)<br>Balto., Md.                                                                                            |  | (County)                                                             |                                   | (State)                                      |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Leonard J. Ruck, Inc., 5305 Harford Rd.                                                                                                                                                                                                                                                                                        |  |                                                                                            |  |                                                                                                                                                             |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 24 1969                                                                                            |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |                                   |                                              |  |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

5076

2

1. 2.

4271B

• • •

1016

• **Stress** •

19-0510 3.00

• • • • •

1998

229

• 2017-08-01 10:00 AM • SPS - 10-162

1940 10 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|
| 02060                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 02055                                                                                                        |  |
| 1. DECEASED-NAME<br>(Type or print) <b>HENRY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 2a. DATE OF DEATH<br>Month <b>2</b> - Day <b>10</b> - Year <b>69</b>                                         |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 2b. HOUR P.<br><b>10:15</b>                                                                                  |  |
| 4. RACE<br><b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. DATE OF BIRTH<br><b>8-17-1887</b>                                                                         |  |
| 6. AGE (In years last birthday)<br><b>81</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b> |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Engineer</b>                                                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                                        |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 13e. STREET AND NUMBER<br><b>705 S. Fagley St., 21224</b>                                                    |  |
| 14. FATHER'S NAME First Middle Last<br><b>John Mack</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katherine ?</b>                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-4306A</b>                                                              |  |
| 17. INFORMANT<br><b>Phillip T. Mack</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Address<br><b>Same</b>                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Broncho pneumonia, terminal</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |                                                                                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                            |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work |  |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                 |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2-3</b> , 19 <b>69</b> , to <b>2-10</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2-10</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                           |  |                                                                                                              |  |
| 22b. SIGNATURE<br><b>Gualberto Gokim, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 22c. DATE SIGNED<br><b>2-10-69</b>                                                                           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>GUALBERTO GOKIM, JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br><b>2-14-69</b>                                                                                  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23d. LOCATION (City or Town) (County) (State)<br><b>7225 Eastern Blvd., Ba. Co., Md.</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>Charles S. Zeiler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25a. REC'D BY REGISTRAR<br><b>901 S. Connelley St. Balto., 21224, Md.</b>                                    |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>FEB 13 1969</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 25c. REGISTRAR'S SIGNATURE<br><b>Charles S. Zeiler</b>                                                       |  |



CERTIFICATE OF DEATH

02056

02061

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                            |                                                                                                           |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 |                                                                      |                                                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Bertha ROSE Manko</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                            | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>17</b> Year <b>69</b>                                          |                                                                                                                                                             |                                                          | 2b. HOUR<br><b>5:30</b>                                                                                     |  |                                                                                                 |                                                                      |                                                        |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>WHITE</b>                    |                                                                                                           | 5. DATE OF BIRTH<br><b>3/28/81</b>                                                                                                                          |                                                          | 6. AGE (In years last birthday)<br><b>87</b> YRS.                                                           |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.                            |                                                                      |                                                        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |                                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                          | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                  |  |                                                                                                 |                                                                      |                                                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                            | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Professional House</b> |                                                                                                                                                             |                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |  |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                  |                                                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                            |                                                                                                           | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                |                                                          | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER<br><b>7111 Park Heights Ave</b> |  |
| 14. FATHER'S NAME<br>First <b>Herman</b> Middle <b>Rose</b> Last <b>Ettlinger</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                            | 15. MOTHER'S MAIDEN NAME<br>First <b>Regina</b> Middle <b>Ettlinger</b> Last <b>Ettlinger</b>             |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 |                                                                      |                                                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) <b>NO</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                               |  |                                            | 16b. SOCIAL SECURITY NO.<br><b>216-46-4047</b>                                                            |                                                                                                                                                             |                                                          | 17. INFORMANT<br><b>PARK TOWERS EAST, APT. 111</b><br><b>MRS. RUTH NEWHOFF, 7111 PARK HGHTS. AVE.</b>       |  |                                                                                                 |                                                                      |                                                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b><br><b>436.0</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension and arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>15 years</b> |  |                                            |                                                                                                           |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 |                                                                      |                                                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic rheumatoid arthritis</b>                                                                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                           |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 |                                                                      |                                                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                                                                             |                                                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                            |  |                                            | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                         |                                                                                                                                                             |                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |  |                                                                                                 |                                                                      |                                                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                      |  |                                            | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |                                                                                                                                                             |                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                |  |                                                                                                 |                                                                      |                                                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/2</b> , 19 <b>69</b> , to <b>2/17</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                   |  |                                            |                                                                                                           |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 |                                                                      |                                                        |  |
| 22b. SIGNATURE<br><b>Louis H. Schaffer, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 |  |                                            |                                                                                                           |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 | 22c. DATE SIGNED                                                     |                                                        |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Louis H. Schaffer, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                            | 22e. ADDRESS<br><b>222 W. Cold Spring Lane</b>                                                            |                                                                                                                                                             |                                                          |                                                                                                             |  |                                                                                                 |                                                                      |                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                            | 23b. DATE<br><b>2-19-69</b>                                                                               |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OHEB SHALOM</b> |                                                                                                             |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                     |                                                                      |                                                        |  |
| 24. FUNERAL DIRECTOR<br><b>Sol Levinson 660 Rensselaer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                            | ADDRESS                                                                                                   |                                                                                                                                                             |                                                          | 25a. REC'D BY REGISTRAR<br><b>FEB 24 1969</b>                                                               |  |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>William J. [Signature]</b>          |                                                        |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03032

UNITED STATES

1951

DATE: 10-10-51 TIME: 10:00 AM

TO: MR. J. EDGAR HOOVER

FROM: MR. J. EDGAR HOOVER

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10-10-51

TIME: 10:00 AM

PLACE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>02062</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02057</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>                                                                                                             |  |  |                                                                                                          |  |  |                                                                                                                                                             |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------|--|--|-----------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | First<br><b>GEORGE</b>                                                                                   |  |  | Middle<br><b>W.</b>                                                                                                                                         |  |  | Last<br><b>MARSHECK</b>                                                                                   |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>7</b> Year <b>69</b>                  |  |  | 2b. HOUR<br><b>8:30AM</b>                     |  |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 4. RACE<br><b>WHITE</b>                                                                                  |  |  | 5. DATE OF BIRTH<br><b>5/22/99</b>                                                                                                                          |  |  | 6. AGE (In years last birthday)<br><b>69</b> YRS.                                                         |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                   |  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                             |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                            |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.                                                        |  |  |                                                                                  |  |  |                                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CO. FT HOWARD</b>                                                                                                                                                                                                                                                                                                                                                                              |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VEH. ADM HOSPITAL</b> |  |  |                                                                                                                                                             |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>FOREMAN</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>YEAST CO.</b>                            |  |  |                                               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                         |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                          |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              |  |  | 13e. STREET AND NUMBER<br><b>7507 RIDDLE AVENUE</b>                              |  |  |                                               |  |  |
| 14. FATHER'S NAME First<br><b>GEO.</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | Middle<br><b>MARSHECK</b>                                                                                |  |  | Last<br><b></b>                                                                                                                                             |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>MARY</b>                                                             |  |  | Middle<br><b>JANE</b>                                                            |  |  | Last<br><b></b>                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)<br><b>YES</b>                                                                                                                                                                                                                                                                   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215 09 68 28</b>                                                          |  |  | 17. INFORMANT Address<br><b>CLIN. RECORDS, VA HOSP. FT HOWARD, MD.</b>                                                                                      |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma Right Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Metastatic Carcinoma Lungs &amp; Lymph Nodes</b> |  |  |                                                                                                          |  |  |                                                                                                                                                             |  |  |                                                                                                           |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Recent</b><br><br><b>Unk.</b> |  |  |                                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arterio Sclerotic Heart Disease Benign Prostatic Hypertrophy</b>                                                                                                                                                                                                                               |  |  |                                                                                                          |  |  |                                                                                                                                                             |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                         |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                        |  |  |                                                                                  |  |  |                                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                 |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><b></b> P.M. <b>19</b>                                |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                           |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/20/69</b> , 19 <b></b> , to <b>2/7/69</b> , 19 <b></b> , that (1) (we) last saw the deceased alive on <b>2/7/69</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                                                      |  |  |                                                                                                          |  |  |                                                                                                                                                             |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
| 22b. SIGNATURE<br><b>Erhard J. Bunyor MD</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |  | DEGREE                                                                                                   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>2/7/69</b>                                                                         |  |  |                                                                                  |  |  |                                               |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ERHARD J. BUNYOR, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                           |  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>                                                         |  |  |                                                                                                                                                             |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                               |  |  | 23b. DATE<br><b>2/10/69</b>                                                                              |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO NATIONAL</b>                                                                                                 |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                               |  |  |                                                                                  |  |  |                                               |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | ADDRESS<br><b>CONNELLY FUNERAL HOME</b>                                                                  |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 11 1969</b>                                                                                                               |  |  | 25b. REGISTRAR'S SIGNATURE<br><b></b>                                                                     |  |  |                                                                                  |  |  |                                               |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | DATE<br><b>MAGE AV. BALTIMORE, MD.</b>                                                                   |  |  |                                                                                                                                                             |  |  |                                                                                                           |  |  |                                                                                  |  |  |                                               |  |  |

02031

02031

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY OF AGRICULTURE

WASHINGTON, D. C.

February 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of January 27, 1911, in relation to the matter of the proposed amendment to the act of March 3, 1907, relating to the exportation of certain agricultural products.

The act of March 3, 1907, relating to the exportation of certain agricultural products, is a law of the United States, and it is the duty of the Secretary of Agriculture to see that it is faithfully executed.

I am, therefore, unable to comply with your request for a change in the act, as it is a law of the United States, and it is the duty of the Secretary of Agriculture to see that it is faithfully executed.

I am, however, glad to hear that you are interested in the matter, and I am sure that you will understand the reasons for my inability to comply with your request.

I am, very respectfully,  
Yours,  
J. B. H. H.

Secretary of Agriculture

Washington, D. C.

Enclosed for you are two copies of the act of March 3, 1907, relating to the exportation of certain agricultural products, as amended by the act of October 3, 1910.

I am, very respectfully,  
Yours,  
J. B. H. H.

Secretary of Agriculture

Washington, D. C.

Enclosed for you are two copies of the act of March 3, 1907, relating to the exportation of certain agricultural products, as amended by the act of October 3, 1910.

I am, very respectfully,  
Yours,  
J. B. H. H.

Secretary of Agriculture

Washington, D. C.

Enclosed for you are two copies of the act of March 3, 1907, relating to the exportation of certain agricultural products, as amended by the act of October 3, 1910.

I am, very respectfully,  
Yours,  
J. B. H. H.

Secretary of Agriculture

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                 |                                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                 |                                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                       |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                 |                                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                       |  |
| 1. DECEASED-NAME<br>(Type or print) <b>CLARENCE</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                 | First <b>C.</b> Middle <b>MAST</b> Last                                        |                                                                                                                                                             |  | 2a. DATE OF DEATH<br><b>February</b> Month <b>13</b> , Day <b>1969</b> Year                     |  | 2b. HOUR<br><b>3:15A</b> M                                                            |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>White</b>                                                                                         |                                                                                | 5. DATE OF BIRTH<br><b>Dec 8, 1897</b>                                                                                                                      |  | 6. AGE (In years<br>lost birthday)<br><b>71</b> YRS.                                            |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                      |                                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.                                                     |  |                                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                                                   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>7714 Old Harford Road</b> |                                                                                | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Retired- Tool Eng.</b>                                     |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |  |                                                                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md.</b>                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY <b>Baltimore</b>                                                                                    |                                                                                | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7714 Old Harford Road</b>                                |  |
| 14. FATHER'S NAME First <b>Daniel</b> Middle <b>K.</b> Last <b>Mast</b>                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                 | 15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>L</b> Last <b>Isnock</b> |                                                                                                                                                             |  |                                                                                                 |  |                                                                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>212-07-9562A</b>                                                                 |                                                                                | 17. INFORMANT<br><b>Mrs. Marie M. Mast</b>                                                                                                                  |  | Address (Same)                                                                                  |  |                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b><br><b>4122</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                                 |                                                                                |                                                                                                                                                             |  |                                                                                                 |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>11 years</b><br><b>11 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>none</b>                                                                                                                                                                                                                                               |  |                                                                                                                 |                                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                |                                                                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                                                                                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                               |                                                                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                 |  |                                                                                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                 |                                                                                | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                                 |  |                                                                                       |  |
| 22a. I certify that (I) (This hospital) attended the deceased from <b>March 1953</b> to <b>Feb 13 1969</b> , that (I) (we) last<br>saw the deceased alive on <b>Jan. 12 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                                  |  |                                                                                                                 |                                                                                |                                                                                                                                                             |  |                                                                                                 |  |                                                                                       |  |
| 22b. SIGNATURE<br><b>C. M. Bacon, M.D.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                 |                                                                                | DEGREE <b>MD</b> ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/><br>PHYS. DIRECTOR               |  | 22c. DATE SIGNED<br><b>2/13/69</b>                                                              |  |                                                                                       |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>A.M. BACON</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                 |                                                                                | 22e. ADDRESS<br><b>2810 Taylor Ave.</b>                                                                                                                     |  |                                                                                                 |  |                                                                                       |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>2/17/69</b>                                                                                     |                                                                                | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                                                                                                 |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |  |                                                                                       |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                 |                                                                                | ADDRESS                                                                                                                                                     |  | 25a. REC'D BY REGISTRAR<br>DATE <b>2 14 1969</b>                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>                                    |  |

83028

RECEIVED

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                              |                                                                                                              |                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 02064                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                              | 02059                                                                                                        |                                                                                                                                                          |
| 1. DECEASED-NAME (Type or print) <b>Margaret</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                              | First <b>Ann</b>                                                                                             | Middle <b>McAvoy</b>                                                                                                                                     |
| 3. SEX <b>female</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                              | 4. RACE <b>white</b>                                                                                         | 5. DATE OF BIRTH <b>Dec. 15, 1877</b>                                                                                                                    |
| 7a. BIRTHPLACE (State or foreign country) <b>Pen a.</b>                                                                                                                                                                                                                                                                                                                                               |                                                                              | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>                                                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>domestic</b>                                                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>U. S. Md.</b>                                                                                                                                                                                                                                                                                        |                                                                              | 13b. COUNTY <b>Pr. Geo.</b>                                                                                  | 13c. CITY OR TOWN <b>Laurel</b>                                                                                                                          |
| 14. FATHER'S NAME First <b>Peter</b> Middle <b>McAvoy</b> Last <b>McAvoy</b>                                                                                                                                                                                                                                                                                                                          |                                                                              | 15. MOTHER'S MAIDEN NAME First <b>Bridgette</b> Middle <b>Bridgette</b> Last <b>Bridgette</b>                |                                                                                                                                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown                                                                                                                                                                                                                                                                                                                                      |                                                                              | 16b. SOCIAL SECURITY NO. <b>135-26-7306A</b>                                                                 | 17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>                                                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                                                              |                                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Urinary tract infection - Endometritis</b>                                                                                                                                                                                                                   |                                                                              |                                                                                                              |                                                                                                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                    | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                              |                                                                                                                                                          |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                               | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                 |                                                                                                                                                          |
| 22a. I certify that (this hospital) attended the deceased from <b>May 16</b> , 19 <b>64</b> , to <b>Feb. 17</b> , 19 <b>69</b> , that (we) last saw the deceased alive on <b>Feb. 17</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.                                        |                                                                              |                                                                                                              |                                                                                                                                                          |
| 22b. SIGNATURE <b>Diomidis Pirovolidis</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                              | DEGREE <b>M.D.</b>                                                                                           | 22c. DATE SIGNED <b>2-17-69</b>                                                                                                                          |
| 22d. PHYSICIAN'S NAME (Type) <b>Diomidis Pirovolidis, M.D.</b>                                                                                                                                                                                                                                                                                                                                        |                                                                              | 22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Md. 21228</b>                                         |                                                                                                                                                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                               | 23b. DATE <b>Feb. 19, 1969</b>                                               | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Vincents Cemetery</b>                                              | 23d. LOCATION (City or Town) (County) (State) <b>Larksville, Lucerne Co., Pa.</b>                                                                        |
| 24. FUNERAL DIRECTOR <b>George J. Gonce</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                              | ADDRESS <b>4001 Ritchie Hwy. Balto, Md.</b>                                                                  | 25a. RECEIVED BY REGISTRAR <b>FEB 21 1969</b>                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                              |                                                                                                              | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                                                                                          |

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000

05000



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54  
30M REV. 1-55

| 02065                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |                                                                                                                           |  |  |  |  | 02060                                                                                                                                                    |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |                                                                                                                           |  |  |  |  | CERTIFICATE OF DEATH                                                                                                                                     |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>SAMUEL</b>                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  | First <b>P</b>                                                                                                            |  |  |  |  | Middle <b>MC</b>                                                                                                                                         |  |  |  |  | Last <b>CARTIN</b>                                                                                                              |  |  |  |  | 2a. DATE OF DEATH <b>2</b> Month <b>14</b> Day <b>69</b> Year        |  |  |  |  | 2b. HOUR <b>12:05 A.M.</b>  |  |  |  |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  | 4. RACE <b>White</b>                                                                                                      |  |  |  |  | 5. DATE OF BIRTH <b>9-7-1893</b>                                                                                                                         |  |  |  |  | 6. AGE (In years last birthday) <b>75</b> YRS.                                                                                  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                                          |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.                                                                                         |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House in the Pines 16 Fusting Avenue</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Gardner</b>                                                   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>LANDSCAPING</b>                                                                            |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                |  |  |  |  | 13b. COUNTY <b>-</b>                                                                                                      |  |  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                       |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |  |  |  | 13e. STREET AND NUMBER <b>815 W. 38th Street</b>                     |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First <b>PATRICK</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | Middle <b>MC</b>                                                                                                          |  |  |  |  | Last <b>CARTIN</b>                                                                                                                                       |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>MARY</b>                                                                                      |  |  |  |  | Middle <b>-</b>                                                      |  |  |  |  | Last <b>-</b>               |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  | (If yes give war or dates of service)                                                                                     |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>212 07 3449</b>                                                                                                              |  |  |  |  | 17. INFORMANT <b>Charles L. McCarton</b> Address <b>Lutherville 1522 Pickett Rd.</b>                                            |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Decomensation</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Cardio-Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>-</b> |  |  |  |  |                                                                                                                           |  |  |  |  |                                                                                                                                                          |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks.</b><br><b>15 yrs.?</b>                                                |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                          |  |  |  |  |                                                                                                                           |  |  |  |  |                                                                                                                                                          |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                          |  |  |  |  |                                                                                                                                                          |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                               |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                           |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                                                               |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                     |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                              |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-31-1968</b> , to <b>2-14-1969</b> , that (I) (we) last saw the deceased alive on <b>2-12-1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                        |  |  |  |  |                                                                                                                           |  |  |  |  |                                                                                                                                                          |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE <b>Wilmer K. Gallagher M.D.</b>                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |                                                                                                                           |  |  |  |  | DEGREE <b>-</b>                                                                                                                                          |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED <b>2-14-69</b>                                      |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |                                                                                                                           |  |  |  |  | 22e. ADDRESS <b>6209 Frederick Ave. Baltimore Md 21208</b>                                                                                               |  |  |  |  |                                                                                                                                 |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |  | 23b. DATE <b>2-18-69</b>                                                                                                  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>                                                                                              |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md 21207</b>                                                     |  |  |  |  |                                                                      |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |                                                                                                                           |  |  |  |  | ADDRESS <b>Baltimore Md</b>                                                                                                                              |  |  |  |  | 25a. REG. BY REGISTRAR <b>FL 19-339</b>                                                                                         |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Judge</b>                              |  |  |  |  |                             |  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02066

02061

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>McKewin, Gordon, H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month <b>02</b> Day <b>19</b> Year <b>69</b>                                            |                                                                                                 | 2b. HOUR<br><b>4:00</b> M                              |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4. RACE<br><b>White</b>                                                                                        | 5. DATE OF BIRTH<br><b>5/28/99</b>                                                                                                                          |                                                                                                              | 6. AGE (In years last birthday)<br><b>69</b> YRS.                                               | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                   |                                                                                                 |                                                        |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Cnty. Gen. Hosp.</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Contractor</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>1 Russern Ct. Apt. 1B</b> |
| 14. FATHER'S NAME First Middle Last<br><b>William H. McKewin</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Cora M. Hedley</b>                                                                                         |                                                                                                              |                                                                                                 |                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                | 16b. SOCIAL SECURITY NO.<br><b>218-30-7443</b>                                                                                                              |                                                                                                              | 17. INFORMANT Address<br><b>Marie McKewin-1 Russern Ct. Apt 1B</b>                              |                                                        |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypertensive arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Stress</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Ind.</b> |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                                                        |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                                                  |                                                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                 |                                                        |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |                                                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                                    |                                                        |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-19</b> , 19 <b>69</b> , to <b>2-19</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-19-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                           |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |
| 22b. SIGNATURE<br><b>Angela A. Topacio</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |                                                                                                              | 22c. DATE SIGNED<br><b>2-19-69</b>                                                              |                                                        |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ANGELA TOPACIO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                | 22e. ADDRESS<br><b>Balto County Gen. Hospital</b>                                                                                                           |                                                                                                              |                                                                                                 |                                                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                | 23b. DATE<br><b>2-22-69</b>                                                                                                                                 |                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                               |                                                        |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |
| 24. FUNERAL DIRECTOR<br><b>Armacost Funeral Chapel-4600 Liberty Hts. Ave</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                | ADDRESS                                                                                                                                                     |                                                                                                              | 25a. REC'D BY REGISTRAR<br><b>FEB 25 1969</b>                                                   |                                                        |
| 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                        |

1934-1935

 $\gamma \in I$ 

1700

1

i ii

1890

U.S. DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-68

| <div style="display: flex; justify-content: space-between;"> <span>02067</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02062</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>                                                                                                                                                                                                                                                                                                                       |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------------------|--|--|--|---------------------------------------------------------------|--|--|--|--------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  | First<br><b>JOSEPH</b>                                                                                           |  |  |  | Middle<br><b>C (A)</b>                                                                                                                                      |  |  |  | Last<br><b>MEISEL</b>                                                                           |  |  |  | 2c. DATE OF DEATH<br>Month Day Year<br><b>Feb. 14, 1969</b>   |  |  |  | 2b. HOUR<br><b>6 p. M.</b>     |  |  |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 4. RACE<br><b>white</b>                                                                                          |  |  |  | 5. DATE OF BIRTH<br><b>4/20/94</b>                                                                                                                          |  |  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.                                               |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                    |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>8112 Pleasant Plains Rd.</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Milkman</b>                                                   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sealtest</b>                                            |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                  |  |  |  | 13c. CITY OR TOWN<br><b>Towson</b>                                                                                                                          |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br><b>8112 Pleasant Plains Rd</b>      |  |  |  |                                |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>John Meisel</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Maria Wilmoth</b>                                               |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-10-3726</b>                                                                   |  |  |  | 17. INFORMANT Address<br><b>Mary Vavra Meisel, wife, above</b>                                                                                              |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u><br><b>4124</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Chronic bronchitis, emphysema.</u> |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                 |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b> |  |  |  |                                |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                 |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                       |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April, 1954</u> , to <u>Feb. 14, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                     |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  |                                                                                                 |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 22b. SIGNATURE<br><u>W. H. Grenzer, M.D.</u> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  | 22c. DATE SIGNED<br><b>2.14.69.</b>                                                             |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. William H. Grenzer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  | 22e. ADDRESS<br><b>1520 E. 33rd St.</b>                                                         |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |  | 23b. DATE<br><b>2/17/69</b>                                                                                      |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                                                                                               |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |  |  |                                                               |  |  |  |                                |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Schimunek Funeral Home, Inc.<br/>3331 Brehms Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |                                                                                                                  |  |  |  |                                                                                                                                                             |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 18 1969</b>                                              |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. ...</i>           |  |  |  |                                |  |  |  |

93008

CERTIFICATE OF DEATH

State of Maryland, County of Baltimore, City of Baltimore, I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 1st day of January, 1900, at the City of Baltimore, Maryland, died

John J. Jones, aged 45 years, of the County of Baltimore, State of Maryland, who was born on the 1st day of January, 1855, at the City of Baltimore, Maryland, and was a resident of the City of Baltimore, Maryland, at the time of his death.

The cause of death was heart disease, which was the result of a long and active life.

Witness my hand and the seal of my office this 1st day of January, 1900.

Dr. J. J. Jones, M.D.

My commission expires on the 1st day of January, 1901.

Attest my hand and the seal of my office this 1st day of January, 1900.

Dr. J. J. Jones, M.D.

My commission expires on the 1st day of January, 1901.

Attest my hand and the seal of my office this 1st day of January, 1900.

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15 1

02068

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02063

|                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                              |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED NAME<br>(Type or print) <b>ELMER WILLIAM</b>                                                                                                                                                                                                                                                                                                                                        |  | First Middle Last                                                                                            |  | 2a. DATE OF DEATH<br>Month <b>FEB.</b> Day <b>14</b> Year <b>1969</b>                                                                                       |  | 2b. HOUR<br><b>1120</b> M                                                                    |                                                                |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br><b>W</b>                                                                                          |  | 5. DATE OF BIRTH<br><b>JULY 9 1895</b>                                                                                                                      |  | 6. AGE (In years lost birthday)<br><b>73</b> YRS.                                            |                                                                |
| 7a. BIRTHPLACE (State or foreign country)<br><b>M.D.</b>                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALT.</b>                                                           |                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>HARRISON M.D.</b>                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>FORT LEE &amp; MURKIN</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Surveyor</b>                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State Roads</b>                                      |                                                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>                                                                                                                                                                                                                                                                                         |  | 13b. COUNTY <b>BALT</b>                                                                                      |  | 13c. CITY OR TOWN<br><b>COCKEYSVILLE</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                |
| 13e. STREET AND NUMBER<br><b>115 GLENMORE AVE</b>                                                                                                                                                                                                                                                                                                                                               |  | 14. FATHER'S NAME<br>First <b>Joseph P</b> Middle <b>MERCER</b> Last <b>—</b>                                |  | 15. MOTHER'S MAIDEN NAME<br>First <b>—</b> Middle <b>Catherine R.</b> Last <b>—</b>                                                                         |  |                                                                                              |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br><b>W.W. One</b>                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.<br><b>220369835</b>                                                                 |  | 17. INFORMANT<br><b>Hosp RETAINED</b>                                                                                                                       |  | Address                                                                                      |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b><br><b>4123</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>years</b> |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cerebral Vascular Accident</b>                                                                                                                                                                                                                         |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                              |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |                                                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                              |                                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> , to <b>Feb 14, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb 14 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                        |  |                                                                                                              |  |                                                                                                                                                             |  |                                                                                              |                                                                |
| 22b. SIGNATURE<br><b>David J. Miller</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                              |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>2-14-69</b>                                                           |                                                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>David J. Miller M.D.</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                              |  | 22e. ADDRESS<br><b>9115 Ricketts Rd.</b>                                                                                                                    |  |                                                                                              |                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>Feb. 17, 1969</b>                                                                            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>                                                                                         |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |                                                                |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                              |  | 25a. REC'D BY REGISTRAR<br><b>FEB 18 1969</b>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Wm. Cook-Brooks</b>                                         |                                                                |

88020

OFFICE OF THE

1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02069

02064

|                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                         |  |                                                                                                                                                          |  |                                                                                              |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                            |  | First <b>Virginia</b> Middle <b>Meyer</b> Last <b>Meyer</b>                                             |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>28</b> Year <b>1969</b>                                                                                |  | 2b. HOUR <b>10:10</b> AM                                                                     |                                              |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE <b>White</b>                                                                                    |  | 5. DATE OF BIRTH<br><b>6-21-1894</b>                                                                                                                     |  | 6. AGE (In years last birthday) <b>74</b> YRS.                                               |                                              |
| 7a. BIRTHPLACE (State or foreign country) <b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Balto.</b> Md.                                                         |                                              |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                  |  | 13b. COUNTY <b>Baltimore</b>                                                                            |  | 13c. CITY OR TOWN <b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| 13e. STREET AND NUMBER <b>3108 Fait Avenue #21224</b>                                                                                                                                                                                                                                                                                                                                                          |  | 14. FATHER'S NAME First <b>Charles</b> Middle <b>W.</b> Last <b>Owens</b>                               |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Kiggins</b> Last <b>Kiggins</b>                                                                     |  |                                                                                              |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO. <b>217-09-0336</b>                                                             |  | 17. INFORMANT <b>Phillip J. Knieriem</b> Address <b>25 Cedarwood Road</b>                                                                                |  |                                                                                              |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                                                         |  |                                                                                                                                                          |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                             |  |                                                                                                         |  |                                                                                                                                                          |  |                                                                                              |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.                                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                                              |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                                              |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-14</b> , 19 <b>69</b> , to <b>2-28</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-28</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                             |  |                                                                                                         |  |                                                                                                                                                          |  |                                                                                              |                                              |
| 22b. SIGNATURE <b>Gualberto Gokim, Jr.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                                                              |  |                                                                                                         |  | 22c. DATE SIGNED <b>2-28-69</b>                                                                                                                          |  |                                                                                              |                                              |
| 22d. PHYSICIAN'S NAME (Type) <b>Gualberto Gokim, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                         |  | 22e. ADDRESS <b>7620 York Road, Towson, Maryland 21204</b>                                                                                               |  |                                                                                              |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE <b>3-3-1969</b>                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>                     |                                              |
| 24. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeiler Inc. 1901-07 Eastern Avenue</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                         |  | 25a. REC'D BY REGISTRAR DATE <b>MAR 3 1969</b>                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                              |                                              |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02070</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02065</div>                                                                                                                                                                                                       |  |                                                                                  |                                                                                                        |                                                                                                                                                             |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <i>Mae</i>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                  | First <i>Mae</i> Middle <i>F.</i> Last <i>Michael</i>                                                  |                                                                                                                                                             |                                                                         | 2a. DATE OF DEATH<br><i>Feb.</i> Month <i>25</i> Day <i>69</i> Year                                         |                                                                                      |                                                                                    | 2b. HOUR<br><i>5.30 PM</i>                       |                                                                                              |                                |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br><i>White</i>                                                          |                                                                                                        | 5. DATE OF BIRTH<br><i>Nov. 14, 1916</i>                                                                                                                    |                                                                         |                                                                                                             | 6. AGE (In years<br>last birthday) <i>52</i> YRS.                                    |                                                                                    | IF UNDER 1 YEAR<br>MONTHS DAYS                   |                                                                                              | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country) <i>Balto.</i>                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                       |                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                         | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.                                                                  |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <i>38 Woodley Ave.</i> |                                                                                                                                                             |                                                                         | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <i>housewife</i> |                                                                                      |                                                                                    | 12b. KIND OF BUSINESS OR<br>INDUSTRY             |                                                                                              |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <i>Md.</i>                                                                                                                                                                                                                                                                                                   |  |                                                                                  | 13b. COUNTY <i>Balto.</i>                                                                              |                                                                                                                                                             | 13c. CITY OR TOWN <i>Reisterstown</i>                                   |                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                    | 13e. STREET AND NUMBER<br><i>38 Woodley Ave.</i> |                                                                                              |                                |
| 14. FATHER'S NAME First <i>Conrad</i> Middle <i>Batz</i> Last <i></i>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                  | 15. MOTHER'S MAIDEN NAME First <i>Loretta</i> Middle <i>Dyer</i> Last <i></i>                          |                                                                                                                                                             |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> no, or (unknown) <i>no</i> (If yes give war or dates of service)                                                                                                                                                                                                                                                                 |  |                                                                                  | 16b. SOCIAL SECURITY NO.<br><i>218-05-7161</i>                                                         |                                                                                                                                                             | 17. INFORMANT Address<br><i>Mr. Joseph E. Michael Reisterstown, Md.</i> |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i><br><i>174X</i> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <i>Carcinoma left breast</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |  |                                                                                  |                                                                                                        |                                                                                                                                                             |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>1 yr 3 mo</i><br><br><i>6 1/2 yrs.</i> |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                           |  |                                                                                  |                                                                                                        |                                                                                                                                                             |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 19a. DATE OF OPERATION<br><i>8-23-62</i>                                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Carcinoma L. breast</i>   |                                                                                                        |                                                                                                                                                             |                                                                         | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |                                                                                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <i>yes</i> |                                                  |                                                                                              |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH<br>(If either, notify medical examiner) <i>none</i>                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                |                                                                                                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE, BUILDING, ETC.) |                                                                                                        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>12-26-45</i> , 19____, to <i>2-25-69</i> , 19____, that (I) (we) lost<br>saw the deceased alive on <i>2-22-69</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                                  |  |                                                                                  |                                                                                                        |                                                                                                                                                             |                                                                         |                                                                                                             |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 22b. SIGNATURE<br><i>D. D. Caples MD</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                  |                                                                                                        | 22c. DATE SIGNED<br><i>2-26-69</i>                                                                                                                          |                                                                         | 22d. PHYSICIAN'S<br>NAME (Type) <i>D. D. Caples, M. D.</i>                                                  |                                                                                      | 22e. ADDRESS<br><i>6 Hanover Rd., Reisterstown, Md. 21136</i>                      |                                                  |                                                                                              |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <i>Burial</i>                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br><i>Feb. 28, 69</i>                                                  |                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Evergreen Memorial</i>                                                                                             |                                                                         | 23d. LOCATION (City or Town) (County) (State)<br><i>Finksburg, Md.</i>                                      |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |
| 24. FUNERAL DIRECTOR<br><i>J. F. Eline &amp; Sons Reisterstown, Md.</i>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                  |                                                                                                        | 25a. REC'D BY REGISTRAR<br>DATE <i>MAR 3 1969</i>                                                                                                           |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><i>W. J. ...</i>                                                              |                                                                                      |                                                                                    |                                                  |                                                                                              |                                |

53853

1120 303 20133

53853

CONNECTION LINE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                   |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                           |  |                                                                              | First                                                                        | Middle                                                                                                                                                      | Last                                                                              | 2a. DATE OF DEATH                                                                                                                         |                                                                                              |                                                 | 2b. HOUR                                     |  |
| Bendiman                                                                                                                                                                                                                                                                                                      |  |                                                                              | H.                                                                           |                                                                                                                                                             | Miller                                                                            | Month Day Year<br>Feb. 9 1969                                                                                                             |                                                                                              |                                                 | 11:15 PM                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                        |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                            |                                                                                   | 6. AGE (In years last birthday)                                                                                                           |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS                  |                                              |  |
| Male                                                                                                                                                                                                                                                                                                          |  | White                                                                        |                                                                              | 8-26-92                                                                                                                                                     |                                                                                   | 76 YRS.                                                                                                                                   |                                                                                              |                                                 |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                                                                        |                                                                                              |                                                 |                                              |  |
| Md.                                                                                                                                                                                                                                                                                                           |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                             |                                                                                   | Baltimore                                                                                                                                 |                                                                                              | Md.                                             |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                             |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                   |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY               |                                              |  |
| Baltimore                                                                                                                                                                                                                                                                                                     |  |                                                                              | Foxleigh Nursing Home                                                        |                                                                                                                                                             |                                                                                   | Coil worker                                                                                                                               |                                                                                              | Bendix                                          |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                 |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN                                                                 |                                                                                                                                           | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                 | 13e. STREET AND NUMBER                       |  |
| Md.                                                                                                                                                                                                                                                                                                           |  |                                                                              | Carroll                                                                      |                                                                                                                                                             | Hampstead                                                                         |                                                                                                                                           | YES                                                                                          |                                                 | 205 S. MAIN ST., Hampstead                   |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                             |  |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| First Middle Last<br>Wm. Henry Miller                                                                                                                                                                                                                                                                         |  |                                                                              | First Middle Last<br>Florence Wilhelm                                        |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)                                                                                                                                                                                                        |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                             |                                                                                   | 17. INFORMANT Address                                                                                                                     |                                                                                              |                                                 |                                              |  |
| NO                                                                                                                                                                                                                                                                                                            |  |                                                                              | 219-01-42484                                                                 |                                                                                                                                                             |                                                                                   | Charles H. Miller Hampstead, Md. 21074                                                                                                    |                                                                                              |                                                 |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 | minutes                                      |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| (b) Arteriosclerosis                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 | unknown                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| (c)                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                            |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| Carcinoma Prostate.                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                           | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                                 |                                              |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                                   | City or Town                                                                                                                              |                                                                                              | County State                                    |                                              |  |
|                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-26, 1969, to 2-9, 1969, that (I) (we) last saw the deceased alive on 2-6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                           |                                                                                              |                                                 |                                              |  |
| 22b. SIGNATURE<br>David I. Miller                                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                              | 22c. DATE SIGNED<br>2-9-69                      |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br>David I. Miller                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   | 22e. ADDRESS<br>9115 Reisterstown Rd Owings Mills                                                                                         |                                                                                              |                                                 |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                     |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                   | 23d. LOCATION (City or Town)                                                                                                              |                                                                                              | (County) (State)                                |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                        |  | Feb. 12, 1969                                                                |                                                                              | Hampstead Cemetery                                                                                                                                          |                                                                                   | Hampstead, Md.                                                                                                                            |                                                                                              |                                                 |                                              |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Tipton - Eline Funeral Home Hampstead, Md.                                                                                                                                                                                                                                    |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1969                                                                                               |                                                                                              | 25b. REGISTRAR'S SIGNATURE<br>Charles H. Miller |                                              |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02072

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02067

|                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ERNEST</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | First Middle Last                                                                                          |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>2 4 69</b>                                                                                                        |  | 2b. HOUR<br><b>4:33 P M</b>                                                          |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>white</b>                                                                                    |  | 5. DATE OF BIRTH<br><b>7-19-86</b>                                                                                                                          |  | 6. AGE (In years lost birthday)<br><b>82</b> YRS.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Amoy, New York</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summit Nursing Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>mechanic</b>                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>                          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Baltimore</b>                                                                            |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Delbert Miller</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Sarah</b>                                              |  |                                                                                                                                                             |  |                                                                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b>118-12-7639</b>                                                             |  | 17. INFORMANT<br><b>CHART - Summit Nursing Home</b>                                                                                                         |  |                                                                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, left lower lobe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD; CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1963</b> |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/3</b> , 19 <b>67</b> , to <b>2/4</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/4</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                         |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |
| 22b. SIGNATURE<br><b>John J. Duda</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22c. DATE SIGNED<br><b>2/5/69</b>                                                                          |  | 22d. PHYSICIAN'S NAME (Type)<br><b>E. KASATI'S, M.D.</b>                                                                                                    |  |                                                                                      |  |
| 22e. ADDRESS<br><b>1801 Freshwater Rd Baltimore, Md 21228</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                            |  |                                                                                                                                                             |  |                                                                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>2/7/69</b>                                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                              |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                            |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 10 1969</b>                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richard S. Young</b>                                |  |

03081

03081



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                                 |                                                                                                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                                                                 |                                                                                                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 02073 Item 23 Film 410 3/20/69 kk CERTIFICATE OF DEATH 02068                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                                 |                                                                                                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Louis Miller</b>                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                                                                 |                                                                                                                                                          | 2a. DATE OF DEATH Month Day Year<br><b>February 1, 1969</b>                                                                         |                                                                                                           |                                                                                   | 2b. HOUR MIN.<br><b>2:30 P.</b>                         |                                                     |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Negro</b>                                                      |                                                                                                                 | 5. DATE OF BIRTH<br><b>Nov. 27, 1895</b>                                                                                                                 |                                                                                                                                     | 6. AGE (In years last birthday) YRS.<br><b>73</b>                                                         |                                                                                   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                                                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>N. C.</b>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                 |                                                                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                     | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                |                                                                                   |                                                         |                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSP.</b> |                                                                                                                                                          |                                                                                                                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>laborer</b> |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                       |                                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                               |  |                                                                              | 13b. COUNTY<br><b>Balto.</b>                                                                                    |                                                                                                                                                          | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                  |                                                                                                           | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                         | 13e. STREET AND NUMBER<br><b>27 North Carey St.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Louis</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                                 |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Della</b>                                                                          |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>Yes, no, or unknown</b>                                                                                                                                                                                                                                                          |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>218-05-3012</b>                                                                  |                                                                                                                                                          | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>                                                                |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial heart failure</b><br><b>485x</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>cardiogenic shock</b><br>(b) <b>hemipneumothorax and suspected</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>pneumonia embolus</b><br>(c) <b>Red CVA.</b> |  |                                                                              |                                                                                                                 |                                                                                                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                                 |                                                                                                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                 |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                   |                                                                                                           | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                                         |                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work                                                                                                                                                                                                                                           |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1963</b> , to <b>Feb. 1, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb. 1, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.                              |  |                                                                              |                                                                                                                 |                                                                                                                                                          |                                                                                                                                     |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 22b. SIGNATURE <b>Rafael H. Marin</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <b>2-3-69</b>                                                                                                                                                               |  |                                                                              |                                                                                                                 |                                                                                                                                                          | 22d. PHYSICIAN'S NAME (Type) <b>Rafael H. Marin, M.D.</b> 22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b> |                                                                                                           |                                                                                   |                                                         |                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                    |                                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                                                                     | 23d. LOCATION (City or Town) (County) (State)                                                             |                                                                                   |                                                         |                                                     |  |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                             |  | <b>2/14/69</b>                                                               |                                                                                                                 | <b>Mt. Calvary</b>                                                                                                                                       |                                                                                                                                     | <b>A.A. Co.</b>                                                                                           |                                                                                   | <b>Md.</b>                                              |                                                     |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Phillips Funeral Home 1727 N. Monroe St.</b>                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                                 |                                                                                                                                                          | 25a. FILED BY REGISTRAR DATE<br><b>FEB 7 1969</b>                                                                                   |                                                                                                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                |                                                         |                                                     |  |

85002

85002

RECEIVED

RECEIVED

DATE

TIME

PLACE

TO

FROM

BY

REMARKS

RECEIVED

RECEIVED

TO

FROM

BY

DATE

TIME

RECEIVED

RECEIVED

TO

FROM

BY

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

| 02074                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |                                                                                                     |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                 |  |  |  |  |                                                                                                                                        |  |  |  |  | 02069                                              |  |                                |  |  |  |  |  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|-----------------------------------------------------------------------------------------------------|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------|--|--------------------------------|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Lucy S. Miller</i>                                                                                                                                                                                                                                                                                                             |  |  |  |  | First Middle Last                                                                                   |  |  |  |  | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>13</i> Year <i>69</i>                                                                                            |  |  |  |  | 2b. HOUR<br>M                                                                                                                          |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                               |  |  |  |  | 4. RACE<br><i>white</i>                                                                             |  |  |  |  | 5. DATE OF BIRTH<br><i>3/12/84</i>                                                                                                                          |  |  |  |  | 6. AGE (In years last birthday)<br><i>84</i> YRS.                                                                                      |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Penn.</i>                                                                                                                                                                                                                                                                                                             |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S. A.</i>                                                      |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.                                                                                             |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Lansdowne</i>                                                                                                                                                                                                                                                                                                                         |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>203 2nd Ave.</i> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>House work</i>                                                |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>own Home</i>                                                                                   |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                      |  |  |  |  | 13b. COUNTY<br><i>Baltimore</i>                                                                     |  |  |  |  | 13c. CITY OR TOWN<br><i>Lansdowne</i>                                                                                                                       |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                        |  |  |  |  | 13e. STREET AND NUMBER<br><i>203 2nd Ave.</i>      |  |                                |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><i>Samuel Kern</i>                                                                                                                                                                                                                                                                                                          |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Catherine Seece</i>                             |  |  |  |  |                                                                                                                                                             |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>No</i>                                                                                                                                                                                                                                                                                      |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>219-2060571</i>                                                      |  |  |  |  | 17. INFORMANT<br>Address<br><i>Lola Monaghan 203 Second Ave.</i>                                                                                            |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4124</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>CVA</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ASCVD</i>               |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i><br><i>?</i>                                                              |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                   |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                    |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                   |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                              |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                        |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 3</i> , 19 <i>69</i> , to <i>Feb 3</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb 3</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  |                                                                                                                                        |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>F. Earl Pass</i>                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br><i>2-4-69</i>                  |  |                                |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>F. Earl Pass</i>                                                                                                                                                                                                                                                                                                                   |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  | 22e. ADDRESS<br><i>4001 Wilkens Ave</i>                                                                                                |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                            |  |  |  |  | 23b. DATE<br><i>2/6/69</i>                                                                          |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadowridge Cemetery</i>                                                                                           |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Persey Maryland</i>                                                                |  |  |  |  |                                                    |  |                                |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Ambrose Inc 1328 Sulphur Spring Rd.</i>                                                                                                                                                                                                                                                                                                    |  |  |  |  |                                                                                                     |  |  |  |  |                                                                                                                                                             |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><i>FEB 6 1969</i>                                                                                   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |  |                                |  |  |  |  |  |  |  |

23030

37130

STATE OF TEXAS

111

2022-2023

2022-2023

2022-2023

2022-2023

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                            |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------|-----------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              | First                                                                        |                                                                     | Middle                                                                                                                                                   |                                                                                         | Last                                                                                         |                                                                                  | 2a. DATE KNOWN OF DEATH                                                         |                                              | 2b. HOUR        |  |
| PHYLLIS MILLER                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 23 1969 |                                              | 2b. HOUR 11:30a |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                                             | 6. AGE (In years last birthday)                                              | IF UNDER 1 YEAR                                                     |                                                                                                                                                          | IF UNDER 24 HRS.                                                                        |                                                                                              | 2c. DATE PRONOUNCED DEAD                                                         |                                                                                 | 2d. HOUR                                     |                 |  |
| Female                                                                                                                                                                                                                                                                                                                                                                                                                                 | White   | Aug. 30, 1936                                                                | 32 YRS.                                                                      | MONTHS DAYS                                                         |                                                                                                                                                          | HOURS MIN.                                                                              |                                                                                              | February Day 23 Year 1969                                                        |                                                                                 | 11:30a                                       |                 |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                              | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                         | 9. COUNTY OF DEATH                                                                           |                                                                                  |                                                                                 |                                              |                 |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                                                                              | U.S.A.                                                                       |                                                                     |                                                                                                                                                          |                                                                                         | Balto. Md.                                                                                   |                                                                                  |                                                                                 |                                              |                 |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                     |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                              |                                                                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                               |                                              |                 |  |
| Towson                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              | G.B.M.C.                                                                     |                                                                     |                                                                                                                                                          | Housewife                                                                               |                                                                                              |                                                                                  | Domestic                                                                        |                                              |                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                          |         |                                                                              | 13b. COUNTY                                                                  |                                                                     | 13c. CITY OR TOWN                                                                                                                                        |                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                  | 13e. STREET AND NUMBER                                                          |                                              |                 |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              | Harford                                                                      |                                                                     | Fork                                                                                                                                                     |                                                                                         |                                                                                              |                                                                                  | Harford Rd. Box. 37                                                             |                                              |                 |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| AYOS -                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              | GREEN                                                                        |                                                                     | ETHEL MARSHALL                                                                                                                                           |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                     | 17. INFORMANT ADDRESS                                                                                                                                    |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              | NONE                                                                         |                                                                     | GILBERT PEARSON 372 N 3rd LAYREL, MD                                                                                                                     |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                 |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 958X DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                         |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                    |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |                                                                                                                                                          |                                                                                         |                                                                                              | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                 |                                              |                 |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                            |         |                                                                              |                                                                              | 21b. TIME OF INJURY Month, Day, Year                                |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                              |                                                                              | 5:06pm 2 22 69                                                      |                                                                                                                                                          | Subject supposedly beaten and set afire                                                 |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State        |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         | Home                                                                         |                                                                              | Harford Rd. Box. 37 Fork Md.                                        |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          |                                                                                         |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                              |                                                                              | CHIEF MEDICAL EXAMINER                                              |                                                                                                                                                          |                                                                                         |                                                                                              | 22b. DATE SIGNED                                                                 |                                                                                 |                                              |                 |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                                                                              | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                                                                                                                                          |                                                                                         |                                                                                              | 2/24/69                                                                          |                                                                                 |                                              |                 |  |
| Edward F. Wilson, M.D.                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                                                                              | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                    |                                                                                                                                                          |                                                                                         |                                                                                              | ADDRESS (Street, city, town, or county)                                          |                                                                                 |                                              |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |         | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                  |                                                                                                                                                          | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 2-25-69                                                                      |                                                                              | Cedar Hill                                                          |                                                                                                                                                          | Anne Arundel Cty Md.                                                                    |                                                                                              |                                                                                  |                                                                                 |                                              |                 |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          | 25a. REC'D BY REGISTRAR                                                                 |                                                                                              | 25b. REGISTRAR'S SIGNATURE                                                       |                                                                                 |                                              |                 |  |
| Francis H. Miller 2101 Redwood Ave.                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              |                                                                              |                                                                     |                                                                                                                                                          | FEB 26 1969                                                                             |                                                                                              | Charles J. Jago                                                                  |                                                                                 |                                              |                 |  |

07030

UNITED STATES DEPARTMENT OF AGRICULTURE

07030

07030

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL 0. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>02076</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02071</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>                                                                                                   |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                              | First Middle Last                                                            |                                                                                                                                                             |                                                                     | 2a. DATE OF DEATH                                                                       |                                                                                                 |                                          | 2b. HOUR                                     |
| WALTER RICHARD MILLER                                                                                                                                                                                                                                                                                                                                                                                                          |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     | Month Day Year<br>2 - 4 - 69                                                            |                                                                                                 |                                          | 7:30 P.                                      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE | 5. DATE OF BIRTH                                                             |                                                                              |                                                                                                                                                             |                                                                     | 6. AGE (In years last birthday)                                                         |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                                              |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                                           | WHITE   | 6-21-1899                                                                    |                                                                              |                                                                                                                                                             |                                                                     | 69 YRS.                                                                                 |                                                                                                 |                                          |                                              |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                      |         | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. COUNTY OF DEATH                                                                      |                                                                                                 |                                          |                                              |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                      |         | U.S.A.                                                                       |                                                                              |                                                                                                                                                             |                                                                     | BALTIMORE Md.                                                                           |                                                                                                 |                                          |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                             |                                                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                                 |                                          | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson, Md.                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              | St. Joseph's Hospital                                                        |                                                                                                                                                             |                                                                     | Utility Man                                                                             |                                                                                                 |                                          | Cement Co.                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                  |         |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN                                                   |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                          | 13e. STREET AND NUMBER                       |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                                                                              | Baltimore                                                                    |                                                                                                                                                             |                                                                     |                                                                                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                          | Box 383-C- Rt. 2 - 21206                     |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                                                                                                                                            |         |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| John Wesley Miller                                                                                                                                                                                                                                                                                                                                                                                                             |         |                                                                              | Hester Jane Kelbaugh                                                         |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                      |         |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                             | 17. INFORMANT Address                                               |                                                                                         |                                                                                                 |                                          |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                                                                              | 218-14-8384                                                                  |                                                                                                                                                             | Rose Miller, Same as #13                                            |                                                                                         |                                                                                                 |                                          |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Post operative hemorrhage</u><br><u>441.2</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                              |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                             |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                             | 20a. AUTOPSY?                                                       |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                          |                                              |
| 2-4-69                                                                                                                                                                                                                                                                                                                                                                                                                         |         | Abdominal aneurysm                                                           |                                                                              |                                                                                                                                                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                         |                                                                                                 |                                          |                                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                       |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                 |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                     | City or Town                                                                            |                                                                                                 | County State                             |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-25</u> , 19 <u>69</u> , to <u>2-4</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2-4</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |                                                                              |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 22c. DATE SIGNED                                                             |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| Ines Cilliani, M.D.                                                                                                                                                                                                                                                                                                                                                                                                            |         | 2/5/69                                                                       |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                   |         | 22e. ADDRESS                                                                 |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                |         | 7620 York Road, Towson, Md. 21204                                            |                                                                              |                                                                                                                                                             |                                                                     |                                                                                         |                                                                                                 |                                          |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |         | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                     | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                                                 |                                          |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                         |         | Feb. 8, 1969                                                                 |                                                                              | Forest Baptist Cemetery                                                                                                                                     |                                                                     | Baltimore Co., Maryland                                                                 |                                                                                                 |                                          |                                              |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                              |                                                                              | 25a. REC'D BY REGISTRAR                                                                                                                                     |                                                                     | 25b. REGISTRAR'S SIGNATURE                                                              |                                                                                                 |                                          |                                              |
| Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                              |                                                                              | FEB 7 1969                                                                                                                                                  |                                                                     | Charles Judge                                                                           |                                                                                                 |                                          |                                              |

02020

02020

02020

[Faint, mostly illegible text lines spanning the page, possibly bleed-through from the reverse side]





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02077

CERTIFICATE OF DEATH

02072

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                     |                                                                                                             |                                     |  |                                                                                                                                                          |  |                                                  |                                                                       |                                                                                  |  |                                                              |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Sadie Turner Mitchell</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                     | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>21</b> Year <b>1969</b>                                   |                                     |  | 2b. HOUR<br><b>5:30</b> AM                                                                                                                               |  |                                                  |                                                                       |                                                                                  |  |                                                              |  |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>W</b> |                                                                                                             | 5. DATE OF BIRTH<br><b>4/7/1889</b> |  | 6. AGE (In years last birthday)<br><b>79</b> YRS.                                                                                                        |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |                                                                       | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>                                  |  |                                                              |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Elkridge, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                               |                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                            |                                                                                  |  |                                                              |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Dulaney Towson N. H.</b> |                                     |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Retired - Social Service</b>                                |  |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |                                                                                  |  |                                                              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                     | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                          |                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |                                                  | 13e. STREET AND NUMBER<br><b>3711 Greenmount Ave.</b>                 |                                                                                  |  |                                                              |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Monroe Mitchell</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                     | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Susie Ross</b>                                             |                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>                                                                            |  |                                                  | 16b. SOCIAL SECURITY NO.<br><b>212-38-0749</b>                        |                                                                                  |  | 17. INFORMANT Address<br><b>Mrs. Harry Silverwood (Same)</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Cardiovascular disease</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |                     |                                                                                                             |                                     |  |                                                                                                                                                          |  |                                                  |                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>6 months</b> |  |                                                              |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |                                     |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |                                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                                                                  |  |                                                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                             |  |                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                           |                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                  |                                                                       |                                                                                  |  |                                                              |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |                                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                  |                                                                       |                                                                                  |  |                                                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 1968</b> , to <b>February 21, 1969</b> , that (I) (we) last saw the deceased alive on <b>February 21, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                        |  |                     |                                                                                                             |                                     |  |                                                                                                                                                          |  |                                                  |                                                                       |                                                                                  |  |                                                              |  |  |
| 22b. SIGNATURE<br><b>A. Allan Speir</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                     |                                                                                                             |                                     |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |                                                  | 22c. DATE SIGNED<br><b>2/21/69</b>                                    |                                                                                  |  |                                                              |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>A. Allan Speir, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                     |                                                                                                             |                                     |  | 22e. ADDRESS<br><b>1501 Pentridge Road</b>                                                                                                               |  |                                                  |                                                                       |                                                                                  |  |                                                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                     | 23b. DATE<br><b>2/24/1969</b>                                                                               |                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>                                                                                                  |  |                                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |                                                                                  |  |                                                              |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                     |                                                                                                             |                                     |  | ADDRESS<br><b>4905 York Rd. Balto. 12, Md.</b>                                                                                                           |  |                                                  | 25a. REC'D BY REGISTRAR<br><b>DATE 24 1969</b>                        |                                                                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>           |  |  |

02072

02072

Michigan

Township

Section

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-66

| 02078                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02073                                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | First Middle Last                                                            |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                                                                                                                                        |  |  |  |  |  |  |  |  |  | 2b. HOUR                                                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Harry                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | Moran Sr                                                                     |  |  |  |  |  |  |  |  |  | February                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 7 1969                                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 4. RACE                                                                      |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH                                                                                                                                         |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birth)                                         |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| Male                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | White                                                                        |  |  |  |  |  |  |  |  |  | Oct. 24, 1879                                                                                                                                            |  |  |  |  |  |  |  |  |  | 89 YRS.                                                              |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | U.S.A.                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  | Baltimore                                                            |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Parkville                                                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 1100 Pelhamwood Rd                                                           |  |  |  |  |  |  |  |  |  | Retired Postman                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN                                                            |  |  |  |  |  |  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | Baltimore                                                                    |  |  |  |  |  |  |  |  |  | Parkville                                                                                                                                                |  |  |  |  |  |  |  |  |  | 1100 Pelhamwood Rd                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| George W Moran                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | Emma Kadel                                                                   |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.                                                     |  |  |  |  |  |  |  |  |  | 17. INFORMANT                                                                                                                                            |  |  |  |  |  |  |  |  |  | Address                                                              |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| No                                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 215-30-3419                                                                  |  |  |  |  |  |  |  |  |  | Ruth E Moran                                                                                                                                             |  |  |  |  |  |  |  |  |  | Same                                                                 |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | Arteriosclerotic Cardio Vascular Disease                                     |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 4124                                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | (b)                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF                                               |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | (c)                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF                                               |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | (c)                                                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                       |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.                            |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 19                                                                           |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>                                                                                                                                             |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1947, to 2/7/69, that (I) (we) last saw the deceased alive on 1/4/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED                                                             |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Thomas L. Worsley                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 2/7/69                                                                       |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                             |  |  |  |  |  |  |  |  |  | 22e. ADDRESS                                                                 |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Thomas L Worsley MD                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 6505 York Rd Baltimore Maryland                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                |  |  |  |  |  |  |  |  |  | 23b. DATE                                                                    |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | 2/10/69                                                                      |  |  |  |  |  |  |  |  |  | Parkwood                                                                                                                                                 |  |  |  |  |  |  |  |  |  | Baltimore, Maryland                                                  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | ADDRESS                                                                      |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR                                                                                                                                  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                           |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Leonard J Ruck Inc                                                                                                                                                                                                                                                                                       |  |  |  |  |  |  |  |  |  | Baltimore, Maryland                                                          |  |  |  |  |  |  |  |  |  | DATE FEB 7 1969                                                                                                                                          |  |  |  |  |  |  |  |  |  | Charles Judge                                                        |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

37000

2010

98

0117

11

X

...

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                     |  |  | First<br><b>ANDREW</b>                                                                                                  |  | Middle<br>-- --                                                                                                                                          |                                                                                                           | Last<br><b>MORANT</b>                                                                           |                                                                             | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>4</b> Year <b>1969</b> |                                              |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                   |  |  | 4. RACE<br><b>Negro</b>                                                                                                 |  | 5. DATE OF BIRTH<br><b>May 5, 1911</b>                                                                                                                   |                                                                                                           |                                                                                                 | 6. AGE (In years last birthday)<br><b>57</b> YRS.                           |                                                                          | 2b. TIME<br><b>10:40</b>                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>                                                                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.A.S.</b>                                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                           | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                          |                                                                             |                                                                          | Md.                                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>                                                                                                                                                                                                                                                                                                                                         |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Administration Hospital</b> |  |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Laborer</b> |                                                                                                 |                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>                 |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                        |  |  | 13b. COUNTY<br><b>Dorchester</b>                                                                                        |  | 13c. CITY OR TOWN<br><b>Cambridge</b>                                                                                                                    |                                                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                             | 13e. STREET AND NUMBER<br><b>720 Baly Road</b>                           |                                              |  |
| 14. FATHER'S NAME<br>First <b>ISAAC</b> Middle <b>MORANT</b> Last <b>WILLIAMS</b>                                                                                                                                                                                                                                                                                                       |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ANNIE</b> Middle <b>WILLIAMS</b> Last <b>WILLIAMS</b>                              |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>Yes</b>                                                                                                                                                                                                                                                                                                       |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW-11 152 22 6956</b>                                                                    |  | 17. INFORMANT<br>Address<br><b>Clinical Reds, VA Hospital, Ft Howard, Md.</b>                                                                            |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS, ADVANCED</b><br><b>150X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                      |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |  |                                                                                                                                                          | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |                                                                                                 |                                                                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                       |  |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                          |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                            |  |                                                                                                                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                              |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>Feb. 4</b> , 19 <b>69</b> , to <b>Feb. 14</b> , 19 <b>69</b> , that (b) (we) last saw the deceased alive on <b>Feb. 14</b> , 19 <b>69</b> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (do not) view the body after death.           |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 22b. SIGNATURE<br><b>Madhav S. Barhanpurkar</b> DEGREE<br>22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV D. BARHANPURKAR, M.D.</b>                                                                                                                                                                                                                                                           |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          | 22c. DATE SIGNED<br><b>2/18/69</b>           |  |
| 22e. ADDRESS<br><b>Va Hospital, Fort Howard, Md.</b>                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                         |  |                                                                                                                                                          |                                                                                                           |                                                                                                 |                                                                             |                                                                          |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                              |  |  | 23b. DATE<br><b>2-21-69</b>                                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                                                                                          |                                                                                                           |                                                                                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |                                                                          |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>Charles R. Law</b>                                                                                                                                                                                                                                                                                                                                           |  |  | 24b. ADDRESS<br><b>802 Madison Ave. Balto Md</b>                                                                        |  |                                                                                                                                                          | 24c. DATE<br><b>FEB 24 1969</b>                                                                           |                                                                                                 |                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>William A. Judge</b>                    |                                              |  |

MEDICAL CERTIFICATION

02039

02039

NAME: [illegible] DOB: [illegible] SEX: [illegible] RACE: [illegible] ETHNICITY: [illegible] RELIGION: [illegible] MARRIAGE: [illegible] CHILDREN: [illegible] Siblings: [illegible] Address: [illegible] City: [illegible] State: [illegible] Zip: [illegible] Country: [illegible] Telephone: [illegible] Email: [illegible] Occupation: [illegible] Education: [illegible] Military Service: [illegible] Criminal Record: [illegible] Financial Status: [illegible] Insurance: [illegible] Health Status: [illegible] Current Residence: [illegible] Previous Residence: [illegible] Travel History: [illegible] Employment History: [illegible] Social Security Number: [illegible] Driver's License: [illegible] Vehicle Registration: [illegible] Other Identifiers: [illegible]

Current Residence: [illegible] Previous Residence: [illegible] Travel History: [illegible] Employment History: [illegible] Social Security Number: [illegible] Driver's License: [illegible] Vehicle Registration: [illegible] Other Identifiers: [illegible]

Health Status: [illegible] Current Residence: [illegible] Previous Residence: [illegible] Travel History: [illegible] Employment History: [illegible] Social Security Number: [illegible] Driver's License: [illegible] Vehicle Registration: [illegible] Other Identifiers: [illegible]

Other Identifiers: [illegible] Social Security Number: [illegible] Driver's License: [illegible] Vehicle Registration: [illegible] Employment History: [illegible] Travel History: [illegible] Previous Residence: [illegible] Current Residence: [illegible]

DECLARATION OF SIGNATURES, ALIEN ONLY

[illegible signature area]

[illegible signature area]

[illegible signature area]

[illegible signature area]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>02089<br/>Item 10 &amp;<br/>Item 23 Film 409 2/11/69 kk</p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>02075</p> </div> </div>                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                          |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                   | 2a. DATE OF DEATH                                                                       |                                                                                              | 2b. HOUR                          |                                              |  |
| Martha                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | H. Morris                                                                    |                                                                                                                                                          |                                                                                   | 2 Month 3 Day 1969                                                                      |                                                                                              | 4:17 PM                           |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                   | 6. AGE (In years last birthday)                                                         |                                                                                              | IF UNDER 1 YEAR MONTHS DAYS       |                                              |  |
| Female                                                                                                                                                                                                                                                                                                                                    |  | White                                                                        |                                                                              | June 13, 1879                                                                                                                                            |                                                                                   | 89 YRS.                                                                                 |                                                                                              |                                   |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                      |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                          |                                                                                   | Baltimore                                                                               |                                                                                              |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                 |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| Towson                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | Holly Hill N. H.                                                             |                                                                                                                                                          |                                                                                   | Housewife                                                                               |                                                                                              |                                   |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                             |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                                 |                                                                                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md.                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              |                                                                                                                                                          | Baltimore                                                                         |                                                                                         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 4010 Mortimer Avenue                         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                         |  |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                         |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| William Harper                                                                                                                                                                                                                                                                                                                            |  |                                                                              | Emma Filmar                                                                  |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)                                                                                                                                                                                                                                                                        |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT Address                                                             |                                                                                         |                                                                                              |                                   |                                              |  |
| NO                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | 218-54-2801                                                                  |                                                                                                                                                          | Mr. M. David Morris 2108 Forrest Ridge Road                                       |                                                                                         |                                                                                              |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                       |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION Street or R.F.D. No.                                                                                                                       |                                                                                   | City or Town                                                                            |                                                                                              | County State                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 12, 1966</u> to <u>Feb 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                              |                                   |                                              |  |
| 22b. SIGNATURE <u>Laurence C. Post M.D.</u>                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          | 22c. DATE SIGNED <u>2/4/69</u>                                                    |                                                                                         |                                                                                              |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Laurence C. Post</u>                                                                                                                                                                                                                                                                                  |  |                                                                              |                                                                              |                                                                                                                                                          | 22e. ADDRESS <u>6805 York Road</u>                                                |                                                                                         |                                                                                              |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                   | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                                              |                                   |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                    |  | February 6, 69                                                               |                                                                              | Lake View                                                                                                                                                |                                                                                   | Harrisville Carroll Md.                                                                 |                                                                                              |                                   |                                              |  |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                          | 25a. REC'D BY REGISTRAR DATE                                                      |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                                                   |                                   |                                              |  |
| Loring Byers Chapel 8728 Liberty Road 21133                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          | FEE 6 1969                                                                        |                                                                                         | <u>[Signature]</u>                                                                           |                                   |                                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-62  
30M REV 1-64

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                          |  |                                                                                                  |  |                                                                                                                                                          |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                  |  |                                                                                                  |  |                                                                                                                                                          |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 02081                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                  |  |                                                                                                                                                          | 02076                                                                                                    |                                                                                   |                                                                      |                                                              |                                                         |  |
| 1. DECEASED-NAME (Type or print) <i>Sister Gertrude Mary (Morrissey)</i>                                                                                                                                                                                                                                                                                     |  |                                                                                                  |  |                                                                                                                                                          | 2a. DATE OF DEATH                                                                                        |                                                                                   |                                                                      | 2b. HOUR                                                     |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                  |  |                                                                                                                                                          | Feb Month 2 Day 69 Year                                                                                  |                                                                                   |                                                                      | 1:15 PM                                                      |                                                         |  |
| 3. SEX <i>F</i>                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE <i>W</i>                                                                                 |  | 5. DATE OF BIRTH <i>Oct 19-1879</i>                                                                                                                      |                                                                                                          |                                                                                   | 6. AGE (In years lost birthday) <i>89</i> YRS.                       |                                                              | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Phila. Pa.</i>                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                          | 9. COUNTY OF DEATH <i>Balto County Md.</i>                                        |                                                                      |                                                              |                                                         |  |
| 10. CITY OR TOWN OF DEATH <i>Stevenson Balto County Md.</i>                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Stella Julie</i> |  |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Religious</i> |                                                                                   |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                            |                                                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>                                                                                                                                                                                                                                                     |  | 13b. COUNTY <i>Balto</i>                                                                         |  | 13c. CITY OR TOWN                                                                                                                                        |                                                                                                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER <i>Stevenson Md.</i>                  |                                                         |  |
| 14. FATHER'S NAME First <i>Michael J.</i> Middle <i>Morrissey</i> Last                                                                                                                                                                                                                                                                                       |  | 15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle Last                                          |  |                                                                                                                                                          |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>                                                                                                                                                                                                                                                                 |  | 16b. SOCIAL SECURITY NO. <i>218-54-4694</i>                                                      |  | 17. INFORMANT <i>Sister Bernard. Marier</i>                                                                                                              |                                                                                                          |                                                                                   | Address                                                              |                                                              |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ASCVD</i><br><i>4124</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                  |  |                                                                                                                                                          |                                                                                                          |                                                                                   |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i> |                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                           |  |                                                                                                  |  |                                                                                                                                                          |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                 |  |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |                                                                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                              |                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                           |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                                                          |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                     |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 28, 1969</i> , to <i>Feb 2, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 28, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                  |  |                                                                                                  |  |                                                                                                                                                          |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 22b. SIGNATURE <i>George H. Beck</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                  |  |                                                                                                  |  | 22c. DATE SIGNED <i>2/3/69</i>                                                                                                                           |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 22d. PHYSICIAN'S NAME (Type) <i>George H. Beck, M.D.</i>                                                                                                                                                                                                                                                                                                     |  |                                                                                                  |  | 22e. ADDRESS <i>6012 Harford Road</i>                                                                                                                    |                                                                                                          |                                                                                   |                                                                      |                                                              |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>                                                                                                                                                                                                                                                                                                      |  | 23b. DATE <i>Feb. 5-1969</i>                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Convent Cemetery</i>                                                                                               |                                                                                                          | 23d. LOCATION (City or Town) (County) (State) <i>Seckester Md.</i>                |                                                                      |                                                              |                                                         |  |
| 24. FUNERAL DIRECTOR <i>Forley-Corranough Funeral Home</i> ADDRESS <i>Balto Md.</i>                                                                                                                                                                                                                                                                          |  |                                                                                                  |  | 25a. REC'D BY REGISTRAR <i>FEB 6 1969</i> DATE                                                                                                           |                                                                                                          | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                   |                                                                      |                                                              |                                                         |  |

3703

RECEIVED BY BUREAU

12030

RECEIVED BY BUREAU  
12030

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 02082 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                            |  |                   |                                                                                                                                                                 |                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                            |                                                                                                                      | 02077                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                      |  |                   |                                                                                                                                                                 |                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                            |                                                                                                                      |                                           |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>ABBY</b> <sup>First</sup> <b>MILDRED</b> <sup>Middle</sup> <b>MULLANEY</b> <sup>Last</sup>                                                                                                                                                                                                                                                                                                            |  |                   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>16</b> Year <b>1969</b>                                                     |                                     |  | 2b. HOUR <b>5:45</b> AM                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                            |                                                                                                                      |                                           |  |
| 3. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE <b>W-</b> |                                                                                                                                                                 | 5. DATE OF BIRTH <b>Sept 5 1900</b> |  | 6. AGE (In years last birthday) <b>68</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                             |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____ |                                                                                                                      | IF UNDER 24 HRS<br>HOURS _____ MIN. _____ |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Ind.</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                         |                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  |                                            | 9. COUNTY OF DEATH <b>Balto</b> Md.                                                                                  |                                           |  |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1825 B Aberdeen</b>                                                             |                                     |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>                                                                                                                                                                                                                                                                                                                                        |  |                                            | 12b. KIND OF BUSINESS OR INDUSTRY <b>NO</b>                                                                          |                                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution) (admission) STATE <b>Ind</b>                                                                                                                                                                                                                                                                                                                                                     |  |                   | 13b. COUNTY <b>Balto</b>                                                                                                                                        |                                     |  | 13c. CITY OR TOWN <b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                            | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |                                           |  |
| 13e. STREET AND NUMBER <b>1825 B Aberdeen Rd</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                   | 14. FATHER'S NAME <b>James</b> <sup>First</sup> <b>Edwards</b> <sup>Middle</sup> <b>—</b> <sup>Last</sup>                                                       |                                     |  | 15. MOTHER'S MAIDEN NAME <b>Louise</b> <sup>First</sup> <b>Smith</b> <sup>Middle</sup> <b>—</b> <sup>Last</sup>                                                                                                                                                                                                                                                                                                                            |  |                                            | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) <b>No</b> (If yes give war or dates of service) |                                           |  |
| 16b. SOCIAL SECURITY NO. <b>213-05-4434D</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                   | 17. INFORMANT <b>James Mullane (son)</b> ADDRESS <b>—</b>                                                                                                       |                                     |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4124</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>—</b><br>(c) <b>—</b> |  |                                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>                                                         |                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                          |  |                   |                                                                                                                                                                 |                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                            |                                                                                                                      |                                           |  |
| 19a. DATE OF OPERATION <b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>                                                                                                       |                                     |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                                      |                                           |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>—</b>                                                                                                                                                                                                                                                                                                                    |  |                   | 21b. TIME OF INJURY Month, Day, Year <b>—</b> HOUR A.M. <b>—</b> P.M. <b>19</b>                                                                                 |                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <b>—</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                            |                                                                                                                      |                                           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                       |  |                   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>—</b>                                                                           |                                     |  | 21f. LOCATION Street or R.F.D. No. <b>—</b> City or Town <b>—</b> County <b>—</b> State <b>—</b>                                                                                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                                      |                                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                   |                                                                                                                                                                 |                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                            |                                                                                                                      |                                           |  |
| ACTUAL SIGNATURE <b>F. T. KASIR JR.</b> EXAMINER'S NAME (Type) <b>F. T. KASIR JR. M.D.</b>                                                                                                                                                                                                                                                                                                                                                   |  |                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                     |  | 22b. DATE SIGNED <b>2/16/69</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                            | ADDRESS (Street, city, town, or county) <b>—</b>                                                                     |                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                   | 23b. DATE <b>2/20/69</b>                                                                                                                                        |                                     |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, National</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                            | 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Maryland</b> (State) <b>—</b>                              |                                           |  |
| 24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc, Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                   | 25a. REC'D BY REGISTRAR <b>FEB 17 1969</b> DATE <b>—</b>                                                                                                        |                                     |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. —</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                            |                                                                                                                      |                                           |  |

02077

02077-0000

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
JAN 10 1968  
100-100000-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                            |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 02083                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 02078                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                 | 2a. DATE OF DEATH                                                                                                               |                                                                      |                                              | 2b. HOUR                          |
| Allen                                                                                                                                                                                                                                                                                           |  |                                                                              | C. Mulligan                                                                  |                                                                                                                                                          |                                                                                 | 2 Month 2 Day 69 Year                                                                                                           |                                                                      |                                              | 9:09AM                            |
| 3. SEX                                                                                                                                                                                                                                                                                          |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                 |                                                                                                                                 | 6. AGE (In years last birthday)                                      |                                              | IF UNDER 1 YEAR MONTHS DAYS       |
| Male                                                                                                                                                                                                                                                                                            |  | White                                                                        |                                                                              | 7-23-00                                                                                                                                                  |                                                                                 |                                                                                                                                 | 68 YRS.                                                              |                                              | IF UNDER 24 HRS. HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 |                                                                                                                                 | 9. COUNTY OF DEATH                                                   |                                              |                                   |
| Maryland                                                                                                                                                                                                                                                                                        |  | U.S.                                                                         |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 | Baltimore Md.                                                        |                                              |                                   |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                       |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                         |                                                                      |                                              | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore Towson                                                                                                                                                                                                                                                                                |  |                                                                              | St. Joseph Hosp.                                                             |                                                                                                                                                          |                                                                                 | Laborer                                                                                                                         |                                                                      |                                              | Harford County Roads              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                   |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                                                                      | 13e. STREET AND NUMBER                       |                                   |
| MD.                                                                                                                                                                                                                                                                                             |  |                                                                              | Harford                                                                      |                                                                                                                                                          | Pylesville                                                                      |                                                                                                                                 |                                                                      | Rt. 1 Box 216                                |                                   |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                               |  |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| First Middle Last                                                                                                                                                                                                                                                                               |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| William Mulligan                                                                                                                                                                                                                                                                                |  |                                                                              | Alice Ayres                                                                  |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No                                                                                                                                                                                                                           |  |                                                                              | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) ----          |                                                                                                                                                          |                                                                                 | 17. INFORMANT Mrs. Elva O. Mulligan                                                                                             |                                                                      | Address RD #1, Box 216 Pylesville, Md. 21132 |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)                                                                                                                                                                                                                      |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute                                                                                                                                                                                                                   |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease                                                                                                                                                                                                                  |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| Diabetes mellitus                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |                                   |
|                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                              |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                                                                                 |                                                                      |                                              |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              |                                                                                                                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                                                                                 |                                                                      |                                              |                                   |
|                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967, to 2-2-69, that (I) (we) last saw the deceased alive on 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 22b. SIGNATURE Wm Carl Ebeling MD                                                                                                                                                                                                                                                               |  |                                                                              | DEGREE                                                                       |                                                                                                                                                          |                                                                                 | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                      | 22c. DATE SIGNED 2-2-69                      |                                   |
| 22d. PHYSICIAN'S NAME (Type) Dr. Ebeling                                                                                                                                                                                                                                                        |  |                                                                              | 22e. ADDRESS 701 St Paul St Balto md                                         |                                                                                                                                                          |                                                                                 |                                                                                                                                 |                                                                      |                                              |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                       |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                 |                                                                                                                                 | 23d. LOCATION (City or Town) (County) (State)                        |                                              |                                   |
| Burial                                                                                                                                                                                                                                                                                          |  | 2/5/1969                                                                     |                                                                              | William Watters                                                                                                                                          |                                                                                 |                                                                                                                                 | Cooptown, Harford, Maryland                                          |                                              |                                   |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                            |  |                                                                              | ADDRESS                                                                      |                                                                                                                                                          |                                                                                 | 25a. REC'D BY REGISTRAR                                                                                                         |                                                                      | 25b. REGISTRAR'S SIGNATURE                   |                                   |
| Charles E. Kurtz                                                                                                                                                                                                                                                                                |  |                                                                              | Jarrettsville, Md. 21084                                                     |                                                                                                                                                          |                                                                                 | DATE FEB 4 1969                                                                                                                 |                                                                      | Charles Judge                                |                                   |

52890

27330

RECEIVED

1900

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02084

02079

|                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                            |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Reginald Heber</b>                                                                                                                                                                                                                                                                                                                                                               |  |  | Middle <b>Murphy.</b>                                                                                       |  |  | Last <b>Murphy.</b>                                                                                                                                         |  |  | 2a. DATE OF DEATH<br><b>2</b> Month <b>28</b> Day <b>69</b> Year                                |  |  | 2b. HOUR<br><b>9 A</b> M                                                                   |  |  |
| 3. SEX<br><b>Male.</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 4. RACE<br><b>White</b>                                                                                     |  |  | 5. DATE OF BIRTH<br><b>9/12/93</b>                                                                                                                          |  |  | 6. AGE (In years lost birthday)<br><b>75</b> YRS.                                               |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                           |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                          |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                                                                 |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>                                              |  |  |                                                                                            |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>                                                                                                                                                                                                                                                                                                                                                                        |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson St. Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during last year, or working life, even if retired)<br><b>Ret. Marine Engineer</b>                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Marine</b>                                              |  |  |                                                                                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                             |  |  | 13b. CITY OR TOWN<br><b>Balto City</b>                                                                      |  |  | 13c. CITY OR TOWN<br><b>Balto</b>                                                                                                                           |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>115 W Monument St.</b>                                        |  |  |
| 14. FATHER'S NAME<br>First <b>Reginald</b> Middle <b>Murphy.</b> Last <b>Murphy.</b>                                                                                                                                                                                                                                                                                                                                    |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Roberta</b> Middle <b>Foster</b> Last <b>Foster</b>                    |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>Yes, War I</b>                                                                                                                                                                                                                                                                                                              |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-24-3073</b>                                                              |  |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>                                                                                       |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema with Chronic Infection</b><br><b>019.0</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Mod. Adv. Piel Tuberculosis duodenal</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Jan 68 (14y)</b><br><b>Jan 67 (24y)</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Chronic Infection</b>                                                                                                                                                                                                                                                          |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 19a. DATE OF OPERATION<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                                                                                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                            |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                           |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                          |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 27, 1964</b> to <b>2/28/69</b> , that (I) (we) last saw the deceased alive on <b>2/28/69</b> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                   |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 22b. SIGNATURE<br><b>W Newcomer</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                             |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>2/28/69</b>                                                              |  |  |                                                                                            |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                             |  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>                                                                                                               |  |  |                                                                                                 |  |  |                                                                                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                              |  |  | 23b. DATE<br><b>3-4-69</b>                                                                                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto. Nat'l</b>                                                                                                   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto., Md.</b>                             |  |  |                                                                                            |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                             |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 3 1969</b>                                                                                                           |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                              |  |  |                                                                                            |  |  |

Baltimore County

St. Wilson St. Hosp.

St. Wilson St. Hosp.

St. Wilson St. Hosp.

St. Wilson St. Hosp.

St. Wilson St. Hosp.

St. Wilson St. Hosp.

St. Wilson St. Hosp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02085

02080

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                            |                                                                                            |                                                                                                                                                             |                                   |                                                                        |                                                  |                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MARIE</b> First <b>THERESA</b> Middle <b>NOHE</b> Last                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                            | 2a. DATE OF DEATH<br><b>February</b> <sup>Month</sup> <b>17</b> <sup>Day</sup> <b>1969</b> |                                                                                                                                                             | 2b. HOUR <b>8:00</b> <sup>M</sup> |                                                                        |                                                  |                                                 |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 4. RACE<br><b>White</b>                                                                                    |                                                                                            | 5. DATE OF BIRTH<br><b>12-13-92</b>                                                                                                                         |                                   | 6. AGE (In years last birthday)<br><b>76</b> YRS.                      | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                               |                                                                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                             |                                                  |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |                                                                                            | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>                                                 |                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                      |                                                  |                                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> <sup>1</sup> COUNTY <b>1</b>                                                                                                                                                                                                                                                                                                       |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                      |                                                                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                |                                   | 13e. STREET AND NUMBER<br><b>2503 McElderry St 21205</b>               |                                                  |                                                 |  |
| 14. FATHER'S NAME First <b>Thomas</b> Middle <b>Neary</b> Last                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                            | 15. MOTHER'S MAIDEN NAME First <b>Rose</b> Middle <b>Donnelly</b> Last                     |                                                                                                                                                             |                                   |                                                                        |                                                  |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                         |  | 16b. SOCIAL SECURITY NO.<br><b>214-16-8081</b>                                                             |                                                                                            | 17. INFORMANT Address <b>21214 F. Ralph Nohe, son, 4617 Arabia Ave.</b>                                                                                     |                                   |                                                                        |                                                  |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the breast, right</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                            |                                                                                            |                                                                                                                                                             |                                   |                                                                        |                                                  |                                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                               |  |                                                                                                            |                                                                                            |                                                                                                                                                             |                                   |                                                                        |                                                  |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |                                                                                            | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                                  |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                          |                                                                                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                   |                                                                        |                                                  |                                                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                                                                                            | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                   |                                                                        |                                                  |                                                 |  |
| 22a. I certify that <del>(I)</del> (this hospital) attended the deceased from <b>2-15-69</b> , 19 <b>69</b> , to <b>2-17</b> , 19 <b>69</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>2-17-69</b> , 19 <b>69</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                        |  |                                                                                                            |                                                                                            |                                                                                                                                                             |                                   |                                                                        |                                                  |                                                 |  |
| 22b. SIGNATURE <b>Freidoon Malek M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                 |  |                                                                                                            |                                                                                            |                                                                                                                                                             |                                   |                                                                        |                                                  | 22c. DATE SIGNED<br><b>2-17-69</b>              |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Freidoon Malek, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                            |                                                                                            | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>                                                                                                    |                                   |                                                                        |                                                  |                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>2/20/69</b>                                                                                |                                                                                            | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                                                                                             |                                   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |                                                  |                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b> ADDRESS<br><b>3331 Brehms Lane</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                            |                                                                                            | 25a. REC'D BY REGISTRAR<br><b>FEB 24 1969</b> DATE                                                                                                          |                                   | 25b. REGISTRAR'S SIGNATURE                                             |                                                  |                                                 |  |

68-11-10

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------------------------------------------------------------------|-----|------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>WILLIAM J. O'CONNOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                     | 2a. DATE OF DEATH<br><b>Feb. 19, 1969</b>                             |                                                                                                                                                             |                                                                                                              | 2b. HOUR<br><b>M</b>                                                                            |                                                                      |                                                                  |     |                                    |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                             |                                                                       | 5. DATE OF BIRTH<br><b>July 4, 1893</b>                                                                                                                     |                                                                                                              | 6. AGE (In years last birthday)<br><b>75</b> YRS.                                               |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |     |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                          |                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                              | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                          |                                                                      |                                                                  | Md. |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's</b> |                                                                       |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Supervisor</b> |                                                                                                 |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>General Mot</b>          |     |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Balto.</b>                                                                        |                                                                       | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER<br><b>2905 Summit Ave.</b>                |     |                                    |  |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas O'Connor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                     | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Katherine Murphy</b> |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                     | 16b. SOCIAL SECURITY NO.<br><b>214 01 6076</b>                        |                                                                                                                                                             | 17. INFORMANT<br><b>family records</b> Address                                                               |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery occlusive infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic atherosclerotic Cardio Vascular dis. 10 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Myocardial Infarct 10 yrs ago</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                    |                                                                       |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                  |     |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                   |                                                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |                                                                       | 21f. LOCATION Street or R.F.D. No City or Town County State                                                                                                 |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 18, 1969</b> , to <b>Feb 19, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                           |  |                                                                                                     |                                                                       |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 22b. SIGNATURE<br><b>Frank T. Kasik, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | DEGREE<br><b>MD</b>                                                                                 |                                                                       | ATTENDING PHYS.<br><input checked="" type="checkbox"/>                                                                                                      |                                                                                                              | MED. DIRECTOR <input type="checkbox"/>                                                          |                                                                      | STAFF PHYS. <input type="checkbox"/>                             |     | 22c. DATE SIGNED<br><b>2/21/69</b> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Frank T. Kasik, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><b>9005 Harford Rd. Balto., Md. 21234</b>                                           |                                                                       |                                                                                                                                                             |                                                                                                              |                                                                                                 |                                                                      |                                                                  |     |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>2/22/69</b>                                                                         |                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Pk.</b>                                                                                          |                                                                                                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Parkville, Balto. Bouny</b>                 |                                                                      |                                                                  |     |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>CHARLES F. EVANS &amp; SON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                     |                                                                       | ADDRESS<br><b>8802 Harford Rd.</b>                                                                                                                          |                                                                                                              | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 24 1969</b>                                           |                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                 |     |                                    |  |

12881

STATION 1000

12881

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

July 1, 1961

12881

12881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02087

02082

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                |  |  |                                                 |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------|--|--|-------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>BRIAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | First <b>NEIL</b>                                                                                           |  |  | Middle <b>O'MAY</b>                                                                                                                                         |  |  | Last                                                                                            |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>6</b> Year <b>1969</b>              |  |  | 2b. HOUR<br><b>7:20a</b>                        |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 4. RACE<br><b>Caucasian</b>                                                                                 |  |  | 5. DATE OF BIRTH<br><b>Jan. 2, 1969</b>                                                                                                                     |  |  | 6. AGE (In years<br>lost birthday) <b>1</b> YRS. <b>4</b> MONTHS <b>4</b> DAYS                  |  |  | IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>4</b>                               |  |  | IF UNDER 24 HRS.<br>HOURS <b>4</b> MIN.         |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                             |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |  |  |                                                                                |  |  |                                                 |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>1904 Dineen Drive</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>None</b>                                                   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |  |  |                                                                                |  |  |                                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 13b. COUNTY <b>Baltimore</b>                                                                                |  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>                                                                                                                         |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>1904 Dineen Drive.</b>                            |  |  |                                                 |  |  |
| 14. FATHER'S NAME<br><b>Gordon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | First <b>O'May</b>                                                                                          |  |  | Middle <b>Kathleen</b>                                                                                                                                      |  |  | Last <b>O'Neil</b>                                                                              |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Kathleen</b> Middle<br><b>O'Neil</b> Last |  |  |                                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                             |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>                                                                     |  |  | 17. INFORMANT (Father) <b>Gordon O'May, 1904 Dineen Drive, Dundalk</b> Address <b>Md.</b>                                                                   |  |  |                                                                                                 |  |  |                                                                                |  |  |                                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7558 Arthrogryposis multiplex</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>YES</b>              |  |  |                                                                                |  |  |                                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                          |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                           |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                                                |  |  |                                                 |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |  |  |                                                                                |  |  |                                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3</b> , 19 <b>69</b> , to <b>1/27</b> , 19 <b>69</b> , that (I) (we) last<br>saw the deceased alive on <b>1/27</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                           |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                |  |  |                                                 |  |  |
| 22b. SIGNATURE<br><b>Rudiger Breitenecker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | DEGREE <b>M. D.</b>                                                                                         |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  |  | 22c. DATE SIGNED<br><b>2/6/69</b>                                                               |  |  |                                                                                |  |  |                                                 |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>Rudiger Breitenecker, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>                                                     |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                |  |  |                                                 |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 23b. DATE<br><b>2/7/69</b>                                                                                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                              |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |  |                                                                                |  |  |                                                 |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>                                                               |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 10 1969</b>                                                                                                          |  |  | 25b. REGISTRAR'S SIGNATURE                                                                      |  |  |                                                                                |  |  |                                                 |  |  |

50000

50000

50000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|                                                                                                                                                          |  |                                                                              |  |                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 02088                                                                                                                                                    |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  | 02083                                                                                                                                                    |  |
| Item 23 Film 410 3/4/69 kk                                                                                                                               |  | CERTIFICATE OF DEATH                                                         |  |                                                                                                                                                          |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                         |  | First Middle Last                                                            |  | 2a. DATE OF DEATH                                                                                                                                        |  |
| MARGARET ELLEN O'NEILL                                                                                                                                   |  |                                                                              |  | 2 Month 23 Day 69 Year                                                                                                                                   |  |
| 3. SEX                                                                                                                                                   |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                         |  |
| Female                                                                                                                                                   |  | white                                                                        |  | 12-2-1896                                                                                                                                                |  |
| 6. AGE (In years last birthday)                                                                                                                          |  | IF UNDER 1 YEAR MONTHS DAYS                                                  |  | IF UNDER 24 HRS. HOURS MIN.                                                                                                                              |  |
| 72 YRS.                                                                                                                                                  |  |                                                                              |  |                                                                                                                                                          |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland                                                                                                                                                 |  | USA                                                                          |  | 9. COUNTY OF DEATH                                                                                                                                       |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |  |
| Ridgeleigh                                                                                                                                               |  | 8511 Chestnut Oak Rd                                                         |  | Housewife                                                                                                                                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                            |  | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                                                                        |  |
| Maryland                                                                                                                                                 |  | Baltimore                                                                    |  | Ridgeleigh                                                                                                                                               |  |
| 14. FATHER'S NAME                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  |
| First Middle Last                                                                                                                                        |  | First Middle Last                                                            |  | —                                                                                                                                                        |  |
| HARRY COULTER                                                                                                                                            |  | SARAH NORRIS                                                                 |  |                                                                                                                                                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                         |  | 16b. SOCIAL SECURITY NO.                                                     |  | 17. INFORMANT Address                                                                                                                                    |  |
| No                                                                                                                                                       |  | —                                                                            |  | Doris E Finnessy New Freedom, PA                                                                                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |                                                                                                                                                          |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                             |  |                                                                              |  |                                                                                                                                                          |  |
| IMMEDIATE CAUSE (a)                                                                                                                                      |  | Carinomatose                                                                 |  |                                                                                                                                                          |  |
| 1570                                                                                                                                                     |  | DUE TO, OR AS A CONSEQUENCE OF                                               |  |                                                                                                                                                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                           |  | (b)                                                                          |  | Carinoma of head of femur                                                                                                                                |  |
|                                                                                                                                                          |  | (c)                                                                          |  |                                                                                                                                                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                       |  |                                                                              |  |                                                                                                                                                          |  |
| 19a. DATE OF OPERATION                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)       |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from                                                                                       |  | 19 68, to February, 19 69, that (I) (we) lost                                |  |                                                                                                                                                          |  |
| saw the deceased alive on Feb 23 1969, and that in (my) (our) opinion death occurred on the date and hour and from the                                   |  | causes stated above, (I) (we) (did) (did not) view the body after death.     |  |                                                                                                                                                          |  |
| 22b. SIGNATURE                                                                                                                                           |  | 22c. DATE SIGNED                                                             |  |                                                                                                                                                          |  |
| E. P. Coffey Jr. mb                                                                                                                                      |  | 2/25/69                                                                      |  |                                                                                                                                                          |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                             |  | 22e. ADDRESS                                                                 |  |                                                                                                                                                          |  |
| E. P. Coffey Jr. SK.                                                                                                                                     |  | 3100 E. Paul St. Balto (28) Md.                                              |  |                                                                                                                                                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |
| Burial                                                                                                                                                   |  | 2/26/69                                                                      |  | DADE Memorial Cem                                                                                                                                        |  |
| 24. FUNERAL DIRECTOR                                                                                                                                     |  | 23d. LOCATION (City or Town) (County) (State)                                |  | 25a. REC'D BY REGISTRAR                                                                                                                                  |  |
| Burger Funeral Home Balto Md                                                                                                                             |  | Miami Florida                                                                |  | FEB 27 1969                                                                                                                                              |  |
|                                                                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE                                                   |  |                                                                                                                                                          |  |
|                                                                                                                                                          |  | William J. Judge                                                             |  |                                                                                                                                                          |  |

28080

33080

STATE OF OHIO

RECEIVED  
JAN 10 1908  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02089

02084

|                                                                                                                                                                                                                                                                                                          |                                  |                                                                                                                                                             |                                                                        |                                                                                                                                         |                                           |                                                                           |                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                                                        | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> |                                           |                                                                           |                                                                                        |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pikesville</b>                                                                                                                                                                                                    |                                  |                                                                                                                                                             |                                                                        | c. LENGTH OF STAY IN 1b<br><b>unknown</b>                                                                                               |                                           |                                                                           |                                                                                        |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>4500 Tapscott Rd.</b>                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                                                        | d. STREET ADDRESS<br><b>4500 Tapscott Rd.</b>                                                                                           |                                           |                                                                           |                                                                                        |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                        |                                  |                                                                                                                                                             |                                                                        |                                                                                                                                         |                                           |                                                                           |                                                                                        |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Robert Jean Palle</b>                                                                                                                                                                                                                                       |                                  |                                                                                                                                                             |                                                                        | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>20,</b> Year <b>19 69</b>                                                                  |                                           |                                                                           |                                                                                        |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                    | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 16, 1917</b>                                | 9. AGE (In years lost birthday) yrs.<br><b>51</b>                                                                                       | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.                                            |                                                                                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sales Engineering</b>                                                                                                                                                                                  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Boatitch Div. Texton Baltio. Md.</b>                                                                                |                                                                        | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>                                                            |                                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |                                                                                        |
| 13. FATHER'S NAME<br><b>Marcel A. Palle</b>                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                             |                                                                        | 14. MOTHER'S MAIDEN NAME<br><b>Clara Forrester</b>                                                                                      |                                           |                                                                           |                                                                                        |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes W.W.II</b>                                                                                                                                                                             |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>                                                                                                                   |                                                                        | 17. INFORMANT<br><b>Mrs. Alice Foster Palle, 4500 Tapscott Rd.</b>                                                                      |                                           |                                                                           |                                                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO<br>(c) _____ |                                  |                                                                                                                                                             |                                                                        |                                                                                                                                         |                                           |                                                                           | INTERVAL BETWEEN ONSET AND DEATH                                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                        |                                  |                                                                                                                                                             |                                                                        |                                                                                                                                         |                                           |                                                                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                       |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |                                                                        |                                                                                                                                         |                                           |                                                                           |                                                                                        |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>                                                                                                                                                                                                                                         |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work                                                | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                                                                                                                                         | 20f. (City or town) (County) (State)      |                                                                           |                                                                                        |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-29</b> , 19 <b>65</b> , to <b>2-20</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>19</b> M, from causes and on the date stated above.                                |                                  |                                                                                                                                                             |                                                                        |                                                                                                                                         |                                           |                                                                           |                                                                                        |
| 22a. SIGNATURE<br><b>Jerome Soller</b>                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                        | 22b. DATE SIGNED<br><b>2/21/69</b>                                                                                                      |                                           |                                                                           |                                                                                        |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jerome Soller MD</b>                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                             |                                                                        | 22d. ADDRESS<br><b>2217 South Rd</b>                                                                                                    |                                           |                                                                           |                                                                                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                               |                                  | 23b. DATE THEREOF<br><b>Feb. 22, 1969</b>                                                                                                                   |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>                                                                         |                                           | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown, Md.</b> |                                                                                        |
| 24. FUNERAL DIRECTOR<br><b>Frank H. Newell, Pikesville 8 Md</b>                                                                                                                                                                                                                                          |                                  |                                                                                                                                                             |                                                                        | 25. REC'D BY REGISTRAR<br><b>FEB 27 1969</b>                                                                                            |                                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                        |                                                                                        |

4560

1990

• 30 2000 •

Calculus Summary

PS-8

501.5-1340

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                       |  |                              |        |                                                                              |  |                                 |  |                                                                                         |  | 2a. DATE KNOWN OF DEATH |     |                                   |         | 2b. HOUR |  |                                              |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|--------|------------------------------------------------------------------------------|--|---------------------------------|--|-----------------------------------------------------------------------------------------|--|-------------------------|-----|-----------------------------------|---------|----------|--|----------------------------------------------|--|--|--|
| First                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                              | Middle |                                                                              |  | Last                            |  |                                                                                         |  | Month                   | Day | Year                              | 7:35 PM |          |  |                                              |  |  |  |
| AMBROSE                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                              | RACHAL |                                                                              |  | PARKER                          |  |                                                                                         |  | 2                       |     | 10                                | 1969    | 7:35 PM  |  |                                              |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE                      |        | 5. DATE OF BIRTH                                                             |  | 6. AGE (in years last birthday) |  | IF UNDER 1 YEAR                                                                         |  | IF UNDER 24 HRS.        |     | 2c. DATE PRONOUNCED DEAD          |         | 2d. HOUR |  |                                              |  |  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | White                        |        | 3-5-1929                                                                     |  | 39 YRS.                         |  | MONTHS                                                                                  |  | DAYS                    |     | Month                             |         | Day      |  |                                              |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? |        | 8. MARRIED                                                                   |  | NEVER MARRIED                   |  | WIDOWED                                                                                 |  | DIVORCED                |     | 9. COUNTY OF DEATH                |         | Md.      |  |                                              |  |  |  |
| Louisiana                                                                                                                                                                                                                                                                                                                                                                                                                              |  | USA                          |        |                                                                              |  |                                 |  |                                                                                         |  |                         |     | Balto.                            |         |          |  |                                              |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |                              |        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                         |     | 12b. KIND OF BUSINESS OR INDUSTRY |         |          |  |                                              |  |  |  |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                              |        | on grounds of Spring Grove                                                   |  |                                 |  | Orderly                                                                                 |  |                         |     | Hospital                          |         |          |  |                                              |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                          |  |                              |        | 13b. COUNTY                                                                  |  |                                 |  | 13c. CITY OR TOWN                                                                       |  |                         |     | 13d. INSIDE CITY LIMITS?          |         |          |  | 13e. STREET AND NUMBER                       |  |  |  |
| Louisiana                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                              |        | Md.                                                                          |  |                                 |  | Alexandria                                                                              |  |                         |     | YES                               |         |          |  | 1711 Polk Street                             |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                              |        | 15. MOTHER'S MAIDEN NAME                                                     |  |                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                            |  |                         |     | 16b. SOCIAL SECURITY NO.          |         |          |  | 17. INFORMANT                                |  |  |  |
| Robert K. Parker                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                              |        | Anna Rachal                                                                  |  |                                 |  | No                                                                                      |  |                         |     | 437-24-4026                       |         |          |  | Hospital Records                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |  |                              |        | 19a. DATE OF OPERATION                                                       |  |                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                       |  |                         |     | 20. AUTOPSY?                      |         |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                           |  |                              |        | IMMEDIATE CAUSE (a)                                                          |  |                                 |  | Arteriosclerotic cardiovascular disease                                                 |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| 4124                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                              |        | DUE TO, OR AS A CONSEQUENCE OF                                               |  |                                 |  |                                                                                         |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                                                                                                                         |  |                              |        | (b)                                                                          |  |                                 |  | DUE TO, OR AS A CONSEQUENCE OF                                                          |  |                         |     |                                   |         |          |  |                                              |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                              |        | (c)                                                                          |  |                                 |  |                                                                                         |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |  |                              |        |                                                                              |  |                                 |  |                                                                                         |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY                                                                                                                                                                                                                                                                                                                                                                                                        |  |                              |        | 21b. TIME OF INJURY Month, Day, Year                                         |  |                                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |                         |     | 20. AUTOPSY?                      |         |          |  | YES                                          |  |  |  |
| CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                              |        | 19                                                                           |  |                                 |  |                                                                                         |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                              |        | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                 |  | 21f. LOCATION Street or R.F.D. No.                                                      |  |                         |     | City or Town                      |         |          |  | County                                       |  |  |  |
| WHILE AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                              |        |                                                                              |  |                                 |  |                                                                                         |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                              |        |                                                                              |  |                                 |  |                                                                                         |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                              |        | M.D.                                                                         |  |                                 |  | CHIEF MEDICAL EXAMINER                                                                  |  |                         |     | 22b. DATE SIGNED                  |         |          |  |                                              |  |  |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                              |        | Edward F. Wilson, M.D.                                                       |  |                                 |  | ASSISTANT MEDICAL EXAMINER                                                              |  |                         |     | DEPUTY MEDICAL EXAMINER           |         |          |  | 2/10/69                                      |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                              |        |                                                                              |  |                                 |  | ADDRESS (Street, city, town, or county)                                                 |  |                         |     |                                   |         |          |  |                                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |  |                              |        | 23b. DATE                                                                    |  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY                                                      |  |                         |     | 23d. LOCATION (City or Town)      |         |          |  | (County)                                     |  |  |  |
| Burial February 14, 1969                                                                                                                                                                                                                                                                                                                                                                                                               |  |                              |        |                                                                              |  |                                 |  | New Cathedral                                                                           |  |                         |     | Baltimore                         |         |          |  | Md.                                          |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                              |        | ADDRESS                                                                      |  |                                 |  | 25a. REC'D BY REGISTRAR                                                                 |  |                         |     | 25b. REGISTRAR'S SIGNATURE        |         |          |  |                                              |  |  |  |
| H.W. Jenkins & Sons Co., Balto., Md.                                                                                                                                                                                                                                                                                                                                                                                                   |  |                              |        |                                                                              |  |                                 |  | FEB 14 1969                                                                             |  |                         |     |                                   |         |          |  |                                              |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                              |        |                                                                              |  |                                 |  | DATE                                                                                    |  |                         |     |                                   |         |          |  |                                              |  |  |  |

U.S. AIR FORCE  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C. 20330

MEMORANDUM FOR THE RECORD

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                          |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|------------------------------|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------|------------------|----------------------------------------------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                  |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                          |  |         | First Middle Last            |                                                                              |  | 2a. DATE OF DEATH                                                                                                                                        |                                 |                                                                                                                                 | 2b. HOUR           |                                               |                  |                                                                      |  |  |  |
| Elizabeth Rose Parks                                                                                                                                                                                                                                                                                         |  |         |                              |                                                                              |  | Feb Month Day 27 Year 1969                                                                                                                               |                                 |                                                                                                                                 | 1:45 A.M.          |                                               |                  |                                                                      |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4. RACE |                              | 5. DATE OF BIRTH                                                             |  |                                                                                                                                                          | 6. AGE (In years last birthday) |                                                                                                                                 | IF UNDER 1 YEAR    |                                               | IF UNDER 24 HRS. |                                                                      |  |  |  |
| Female                                                                                                                                                                                                                                                                                                       |  | WHITE   |                              | June 30, 1884                                                                |  |                                                                                                                                                          | 84 YRS.                         |                                                                                                                                 | MONTHS DAYS        |                                               | HOURS MIN        |                                                                      |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                    |  |         | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |                                                                                                                                 | 9. COUNTY OF DEATH |                                               |                  |                                                                      |  |  |  |
| Md.                                                                                                                                                                                                                                                                                                          |  |         | U.S.A.                       |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 | Baltimore          |                                               |                  | Md.                                                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    |  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                                                                                                                                          |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                         |                    |                                               |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| Garrison                                                                                                                                                                                                                                                                                                     |  |         |                              | Foxleigh                                                                     |  |                                                                                                                                                          |                                 | Hacienda                                                                                                                        |                    |                                               |                  | Own home                                                             |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                |  |         |                              | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                                                                        |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                    | 13e. STREET AND NUMBER                        |                  |                                                                      |  |  |  |
| Md.                                                                                                                                                                                                                                                                                                          |  |         |                              | Baltimore                                                                    |  | Towson                                                                                                                                                   |                                 |                                                                                                                                 |                    | 8612 Chestnut Oak Rd.                         |                  |                                                                      |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  |         |                              | 15. MOTHER'S MAIDEN NAME                                                     |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| George Polster                                                                                                                                                                                                                                                                                               |  |         |                              | UNKNOWN                                                                      |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)                                                                                                                                                                                                     |  |         |                              | 16b. SOCIAL SECURITY NO.                                                     |  |                                                                                                                                                          |                                 | 17. INFORMANT                                                                                                                   |                    |                                               |                  | Address                                                              |  |  |  |
| No                                                                                                                                                                                                                                                                                                           |  |         |                              | 215-10-7576D                                                                 |  |                                                                                                                                                          |                                 | Hospital Records                                                                                                                |                    |                                               |                  |                                                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                    |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                 |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| IMMEDIATE CAUSE (a) Carcinoma of the Breast                                                                                                                                                                                                                                                                  |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  | 22 years                                                             |  |  |  |
| 174X DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                          |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                               |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                           |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                          |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                           |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                                                                                                                                          |                                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                          |                    |                                               |                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|                                                                                                                                                                                                                                                                                                              |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                           |  |         |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                                                                                                                                          |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                 |                    |                                               |                  |                                                                      |  |  |  |
|                                                                                                                                                                                                                                                                                                              |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                     |  |         |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                                                                                                                                          |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                    |                    |                                               |                  |                                                                      |  |  |  |
|                                                                                                                                                                                                                                                                                                              |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-17-1969, to 2-27-1969, that (I) (we) last saw the deceased alive on 2-26-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |  |         |                              | DEGREE                                                                       |  |                                                                                                                                                          |                                 | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                    |                                               |                  | 22c. DATE SIGNED                                                     |  |  |  |
| David J. Miller                                                                                                                                                                                                                                                                                              |  |         |                              |                                                                              |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  | 2-27-69                                                              |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                 |  |         |                              | 22e. ADDRESS                                                                 |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| David J. Miller                                                                                                                                                                                                                                                                                              |  |         |                              | 9115 Reisterstown Rd. Coopers Mt. Md.                                        |  |                                                                                                                                                          |                                 |                                                                                                                                 |                    |                                               |                  |                                                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |  |         |                              | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                 |                                                                                                                                 |                    | 23d. LOCATION (City or Town) (County) (State) |                  |                                                                      |  |  |  |
| Burial                                                                                                                                                                                                                                                                                                       |  |         |                              | March 1, 1969                                                                |  | St. Andrew's Cemetery Baltimore                                                                                                                          |                                 |                                                                                                                                 |                    | Md.                                           |                  |                                                                      |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                         |  |         |                              | ADDRESS                                                                      |  |                                                                                                                                                          |                                 | 25a. RECEIVED BY REGISTRAR                                                                                                      |                    |                                               |                  | 25b. REGISTRAR'S SIGNATURE                                           |  |  |  |
| Frank D. Howell                                                                                                                                                                                                                                                                                              |  |         |                              | Pikesville Md.                                                               |  |                                                                                                                                                          |                                 | MAR 5 1969                                                                                                                      |                    |                                               |                  | J. J. Judge                                                          |  |  |  |

MEDICAL CERTIFICATION

X

90

03

1

1

33950

STATE OF TEXAS

19050

IN SENATE

January 12, 1905

HOUSE

19050

19050



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-7-68

| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                          |                              | First                                                                        | Middle                                                                                                                                                   | Last                                                                                                                                   | 2a. DATE OF DEATH                                                                            | 2b. HOUR                                                             |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|
| MARY ANNA PETRI                                                                                                                                                                                                                                                                                              |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        | Feb. Month 3 Day 69 Year                                                                     | M                                                                    |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                       | 4. RACE                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                        | 6. AGE (In years last birthday)                                                              | IF UNDER 1 YEAR MONTHS                                               | IF UNDER 24 HRS. HOURS MIN.                  |
| FEMALE                                                                                                                                                                                                                                                                                                       | WHITE                        |                                                                              | Feb. 2, 1886                                                                                                                                             |                                                                                                                                        | 23 YRS.                                                                                      |                                                                      |                                              |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                    | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH                                                                           |                                                                      |                                              |
| Md                                                                                                                                                                                                                                                                                                           | U.S.A                        |                                                                              |                                                                                                                                                          |                                                                                                                                        | BALTIMORE Md.                                                                                |                                                                      |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                              |
| BALTIMORE                                                                                                                                                                                                                                                                                                    |                              | FOREST HAVEN NURTHOME                                                        |                                                                                                                                                          | HOUSE WIFE                                                                                                                             |                                                                                              |                                                                      |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                |                              | 13b. COUNTY                                                                  | 13c. CITY OR TOWN                                                                                                                                        |                                                                                                                                        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER                                               |                                              |
| Md.                                                                                                                                                                                                                                                                                                          |                              | BALTO - BALTO.                                                               | BALTO.                                                                                                                                                   |                                                                                                                                        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          | 410 N. LAKEWOOD AVE.                                                 |                                              |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                          |                              |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                                                                                               |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| GEORGE SURTH                                                                                                                                                                                                                                                                                                 |                              |                                                                              | CATHERINE FRANZ                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)                                                                                                                                                                                                       |                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT Address                                                                                                                  |                                                                                              |                                                                      |                                              |
| NO                                                                                                                                                                                                                                                                                                           |                              |                                                                              |                                                                                                                                                          | Wendell A. Petri 504 N. Linwood Ave                                                                                                    |                                                                                              |                                                                      |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                    |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                 |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| IMMEDIATE CAUSE (a) ACUTE SUPPURATIVE EDEMA - PNEUMONIA                                                                                                                                                                                                                                                      |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                               |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| (b) BRONCHOPNEUMONIA - VASCULAR DISEASE                                                                                                                                                                                                                                                                      |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                               |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| (c)                                                                                                                                                                                                                                                                                                          |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                           |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                              |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                           |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                        |                                                                                              |                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                              |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                     |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                           |                                                                                              |                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                              |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7, 1966, to 2/3, 1969, that (I) (we) last saw the deceased alive on 2/3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                              |                                                                      |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |                              |                                                                              |                                                                                                                                                          | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                              | 22c. DATE SIGNED                                                     |                                              |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                 |                              |                                                                              |                                                                                                                                                          | 22e. ADDRESS                                                                                                                           |                                                                                              |                                                                      |                                              |
| JOHN H. SHAW M.D.                                                                                                                                                                                                                                                                                            |                              |                                                                              |                                                                                                                                                          | 5805 SUMMIT AVE. BALTO. MD.                                                                                                            |                                                                                              |                                                                      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |                              | 23b. DATE                                                                    |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                     |                                                                                              | 23d. LOCATION (City or Town) (County) (State)                        |                                              |
| Burial                                                                                                                                                                                                                                                                                                       |                              | 2-6-69                                                                       |                                                                                                                                                          | Holy Redeemer Cmt.                                                                                                                     |                                                                                              | Baltimore Md.                                                        |                                              |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                 |                              |                                                                              |                                                                                                                                                          | 25a. REGISTRAR 1969                                                                                                                    |                                                                                              | 25b. REGISTRAR'S SIGNATURE                                           |                                              |
| B. DABROWSKI 2818 E. BALTIMORE ST.                                                                                                                                                                                                                                                                           |                              |                                                                              |                                                                                                                                                          | DATE                                                                                                                                   |                                                                                              |                                                                      |                                              |

7205

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                           |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------|--|----------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                   |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                          |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                           |  |  | First                                                                        |  | Middle                                                                                                                                                      |                                                                                 | Last                            |  | 2a. DATE OF DEATH                                                    |                                              |  |
| HILDA                                                                                                                                                                                                                                                                                                         |  |  | PFLAUM                                                                       |  | February                                                                                                                                                    |                                                                                 | Month 1, Day 1969               |  | 2b. HOUR                                                             |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                        |  |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                            |                                                                                 | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR                                                      |                                              |  |
| Female                                                                                                                                                                                                                                                                                                        |  |  | White                                                                        |  | September 14, 1901                                                                                                                                          |                                                                                 | 67 YRS.                         |  | MONTHS DAYS HOURS MIN.                                               |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 | 9. COUNTY OF DEATH              |  | 10. CITY OR TOWN OF DEATH                                            |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                      |  |  | U.S.A.                                                                       |  |                                                                                                                                                             |                                                                                 | Baltimore                       |  | Halethorpe                                                           |                                              |  |
| 11a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                 |  |  | 11b. CITY OR TOWN                                                            |  | 11c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |                                                                                 | 11d. STREET AND NUMBER          |  | 11e. KIND OF BUSINESS OR INDUSTRY                                    |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                      |  |  | Halethorpe                                                                   |  |                                                                                                                                                             |                                                                                 | 1406 Avon Court                 |  |                                                                      |                                              |  |
| 12. FATHER'S NAME                                                                                                                                                                                                                                                                                             |  |  | 13. MOTHER'S MAIDEN NAME                                                     |  | 14. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)                                                      |                                                                                 | 15. SOCIAL SECURITY NO.         |  | 16. INFORMANT                                                        |                                              |  |
| First Middle Last                                                                                                                                                                                                                                                                                             |  |  | First Middle Last                                                            |  | No                                                                                                                                                          |                                                                                 | 216-07-4476                     |  | Mr. John Pflaum, 1406 Avon Court 21227                               |                                              |  |
| Horner                                                                                                                                                                                                                                                                                                        |  |  | Elizabeth                                                                    |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                     |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio - Vascular Disease                                                                                                                                                                                                                                 |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      | Sudden                                       |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                           |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                            |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| (c)                                                                                                                                                                                                                                                                                                           |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                            |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                        |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                                                                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                            |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                 |  |                                                                      |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                       |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                 |  |                                                                      |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1967, to 2/1, 1969, that (I) (we) last saw the deceased alive on 2/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                                                              |  |                                                                                                                                                             |                                                                                 |                                 |  |                                                                      |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |                                                                                                                                                             | 22c. DATE SIGNED                                                                |                                 |  |                                                                      |                                              |  |
| James N. Frederick                                                                                                                                                                                                                                                                                            |  |  |                                                                              |  |                                                                                                                                                             | 2/3/69                                                                          |                                 |  |                                                                      |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                  |  |  |                                                                              |  |                                                                                                                                                             | 22e. ADDRESS                                                                    |                                 |  |                                                                      |                                              |  |
| James N. Frederick                                                                                                                                                                                                                                                                                            |  |  |                                                                              |  |                                                                                                                                                             | 1311 Francis Avenue, Balto., Md. 21227                                          |                                 |  |                                                                      |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                     |  |  | 23b. DATE                                                                    |  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY                                              |                                 |  | 23d. LOCATION (City or Town) (County) (State)                        |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                        |  |  | 2-5-1969                                                                     |  |                                                                                                                                                             | Baltimore National Cem.                                                         |                                 |  | Baltimore, Maryland                                                  |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                          |  |  |                                                                              |  |                                                                                                                                                             | 25a. REC'D BY REGISTRAR                                                         |                                 |  | 25b. REGISTRAR'S SIGNATURE                                           |                                              |  |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                                    |  |  |                                                                              |  |                                                                                                                                                             | DATE FEB 4 1969                                                                 |                                 |  | Charles Judge                                                        |                                              |  |

02008

02008

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1908

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1907

ALBANY:

THE STATE PRINTING OFFICE

1908

Price, 10 CENTS

Per copy, 5 CENTS

By mail, 10 CENTS

Postage paid

NEW YORK

1908

1908

1908

1908

1908

1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 1. DECEASED-NAME<br>(Type or print) <u>Phabus</u> <sup>First</sup> <u>Sedberry</u> <sup>Middle</sup> <u>MARY</u> <sup>Last</sup>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |                                                                                                              |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month <u>Feb</u> Day <u>12</u> Year <u>69</u>                              |                                                                                         | 2b. HOUR<br><u>3:00 PM</u>                                                         |                                                    |                                                                                              |
| 3. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><u>White</u>                                                                                   |                                                                                                              | 5. DATE OF BIRTH<br><u>11-7-97</u>                                                                                                                          |                                                                                                 | 6. AGE (In years lost birthday)<br><u>71</u> YRS.                                       |                                                                                    | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u> |                                                                                              |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Georgia</u>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                |                                                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                 | 9. COUNTY OF DEATH<br><u>BALTIMORE</u> Md.                                              |                                                                                    |                                                    |                                                                                              |
| 10. CITY OR TOWN OF DEATH<br><u>RANDALLSTOWN</u>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>BALTIMORE CO. GENERAL</u> |                                                                                                                                                             |                                                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                    | 12b. KIND OF BUSINESS OR INDUSTRY                  |                                                                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           | 13b. CITY OR TOWN<br><u>Balto</u>                                                                            |                                                                                                                                                             | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                         | 13e. STREET AND NUMBER<br><u>3203 N. Charles St. 21218</u>                         |                                                    |                                                                                              |
| 14. FATHER'S NAME First <u>Oscar</u> Middle <u>Sedberry</u> Last <u>  </u>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                                                              |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME First <u>Anna</u> Middle <u>Crumpleton</u> Last <u>  </u>              |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><u>NO</u>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           | 16b. SOCIAL SECURITY NO.<br><u>YES</u>                                                                       |                                                                                                                                                             | 17. INFORMANT<br><u>John Baker</u> Address <u>Equitable Building</u>                            |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA + CONGESTION</u><br><u>4124</u> DUE TO, OR AS A CONSEQUENCE OF <u>ATRIAL FIBRILLATION (EKG)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> |  |                                                                                                           |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>TERMINAL</u><br><u>DAYS</u><br><u>YRS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                                                              |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>YES</u> |                                                    |                                                                                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u><br>P.M. <u>  </u> |                                                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |                                                                                                              | 21f. LOCATION Street or R.F.D. No. <u>  </u>                                                                                                                |                                                                                                 | City or Town <u>  </u>                                                                  |                                                                                    | County <u>  </u> State <u>  </u>                   |                                                                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 30</u> , 19 <u>69</u> , to <u>Feb 12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb 12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                        |  |                                                                                                           |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 22b. SIGNATURE<br><u>G. Tranter MD</u>                                                                                                                                                                                                                                                                                                                                                                                                                          |  | DEGREE <u>MD</u>                                                                                          |                                                                                                              | ATTENDING PHYS. <input type="checkbox"/>                                                                                                                    |                                                                                                 | MED. DIRECTOR <input type="checkbox"/>                                                  |                                                                                    | STAFF PHYS. <input checked="" type="checkbox"/>    |                                                                                              |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Simon Calle, MD Pathologist</u>                                                                                                                                                                                                                                                                                                                                                                                              |  | 22e. ADDRESS<br><u>  </u>                                                                                 |                                                                                                              |                                                                                                                                                             |                                                                                                 |                                                                                         |                                                                                    |                                                    |                                                                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><u>2-15-69</u>                                                                               |                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cemetery</u>                                                                                           |                                                                                                 | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u>             |                                                                                    |                                                    |                                                                                              |
| 24. FUNERAL DIRECTOR<br><u>Arinacost Funeral Chapel-4600 Liberty Hts. Ave</u>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |                                                                                                              | ADDRESS<br><u>  </u>                                                                                                                                        |                                                                                                 | 25a. REC'D BY REGISTRAR<br><u>FEB 19 1969</u>                                           |                                                                                    | 25b. REGISTRAR'S SIGNATURE<br><u>  </u>            |                                                                                              |

10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                      |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|------------------------------------------------------------------------------|------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--|-------------------------------------------------------------------------------------------------|--|------------------------|----------------------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                              |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                     |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                      |  |         | First Middle Last                                                            |                  |  | 2a. DATE OF DEATH                                                                                                                                           |                                 |  | 2b. HOUR                                                                                        |  |                        |                                              |  |  |  |
| Frank G. Phelps                                                                                                                                                                                                                                                                                                                                                          |  |         |                                                                              |                  |  | February 8 <sup>th</sup> 1969                                                                                                                               |                                 |  | 3:10 P <sup>M</sup>                                                                             |  |                        |                                              |  |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE |                                                                              | 5. DATE OF BIRTH |  |                                                                                                                                                             | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR                                                                                 |  | IF UNDER 24 HRS        |                                              |  |  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                     |  | White   |                                                                              | 7-5-05           |  |                                                                                                                                                             | 63 YRS.                         |  | MONTHS DAYS                                                                                     |  | HOURS MIN              |                                              |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                |  |         | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH                                                                              |  |                        |                                              |  |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                |  |         | U.S.A.                                                                       |                  |  |                                                                                                                                                             |                                 |  | Baltimore                                                                                       |  |                        | Md.                                          |  |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |                        |                                              |  |  |  |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                |  |         | St. Joseph Hospital                                                          |                  |  | Asst. Mg. Retired                                                                                                                                           |                                 |  | Reid Avery                                                                                      |  |                        |                                              |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                            |  |         | 13b. COUNTY                                                                  |                  |  | 13c. CITY OR TOWN                                                                                                                                           |                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |                                              |  |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                 |  |         | Baltimore                                                                    |                  |  |                                                                                                                                                             |                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  | 2626 Joppa Road, 21234 |                                              |  |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                        |  |         | 15. MOTHER'S MAIDEN NAME                                                     |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                        |  |         | First Middle Last                                                            |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| Frank Phelps                                                                                                                                                                                                                                                                                                                                                             |  |         | Alice                                                                        |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, (g, or, or unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                           |  |         | 16b. SOCIAL SECURITY NO.                                                     |                  |  | 17. INFORMANT                                                                                                                                               |                                 |  | Address                                                                                         |  |                        |                                              |  |  |  |
| No                                                                                                                                                                                                                                                                                                                                                                       |  |         | 214-05-3989                                                                  |                  |  | Wife: Margaret                                                                                                                                              |                                 |  | same                                                                                            |  |                        |                                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                             |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| IMMEDIATE CAUSE (a) <u>Urinary Retention</u>                                                                                                                                                                                                                                                                                                                             |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                           |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                                                                                           |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| (b) <u>Carcinomatosis</u>                                                                                                                                                                                                                                                                                                                                                |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                           |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| (c) <u>Lymphoma</u>                                                                                                                                                                                                                                                                                                                                                      |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                       |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |                        |                                              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                 |  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                             |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-5-69</u> , 19 <u>69</u> , to <u>2-8-69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-8-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |                                                                              |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                           |  |         | 22c. DATE SIGNED                                                             |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| <u>Jaime Punzalan M.D.</u>                                                                                                                                                                                                                                                                                                                                               |  |         | 2-8-69                                                                       |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                             |  |         | 22e. ADDRESS                                                                 |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| Jaime Punzalan, M.D.                                                                                                                                                                                                                                                                                                                                                     |  |         | 7620 York Road, Towson, Md. 21204                                            |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                |  |         | 23b. DATE                                                                    |                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                 |  | 23d. LOCATION (City or Town) (County) (State)                                                   |  |                        |                                              |  |  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                   |  |         | Feb. 12, 1969                                                                |                  |  | Oaklawn Cemetery                                                                                                                                            |                                 |  | Baltimore, Maryland                                                                             |  |                        |                                              |  |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                     |  |         | 25a. RECEIVED BY REGISTRAR                                                   |                  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                  |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |
| Wm. Cook-Brooks Towson, 1050 York Road, Towson, Maryland 21204                                                                                                                                                                                                                                                                                                           |  |         | FEB 10 1969                                                                  |                  |  |                                                                                                                                                             |                                 |  |                                                                                                 |  |                        |                                              |  |  |  |

00000

00000

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

02095

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02091

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                             |                                                                 |                                                                                                                                                             |  |                                                                                                 |                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <i>Frieda Mae Phillips</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                             | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>9</i> Year <i>69</i> |                                                                                                                                                             |  | 2b. HOUR<br><i>6:45</i> M                                                                       |                                                                               |
| 3. SEX<br><i>Female</i>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><i>White</i>                                                                                     |                                                                 | 5. DATE OF BIRTH<br><i>10-25-99</i>                                                                                                                         |  | 6. AGE (In years last birthday)<br><i>69</i> YRS.                                               |                                                                               |
| 7a. BIRTHPLACE (State or foreign country)<br><i>BALTO.</i>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                  |                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>BALTO.</i>                                                             |                                                                               |
| 10. CITY OR TOWN OF DEATH<br><i>Randalls Town</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>BALTO. Co. Gen. Hosp</i> |                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><i>BALTO.</i>                                                                                |                                                                 | 13c. CITY OR TOWN<br><i>Balto</i>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                               |
| 14. FATHER'S NAME<br>First <i>Harry</i> Middle <i>Wick</i> Last <i>Wick</i>                                                                                                                                                                                                                                                                                                                                                                                    |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Anna</i> Middle <i>Nichols</i> Last <i>Nichols</i>                     |                                                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |                                                                                                 |                                                                               |
| 16b. SOCIAL SECURITY NO.<br><i>1541</i>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 17. INFORMANT<br><i>William H. Phillips - Hosp. Record</i>                                                  |                                                                 | 18. ADDRESS<br><i>7325 Windsor Mill Rd.</i>                                                                                                                 |  |                                                                                                 |                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Respiratory arrest</i><br><i>1541</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Chronic Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>as a result of the return to widespread metastatic disease</i> |  |                                                                                                             |                                                                 |                                                                                                                                                             |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i><br><i>days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)                                                                                                                                                                                                                                                                                                                            |  |                                                                                                             |                                                                 |                                                                                                                                                             |  |                                                                                                 |                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                                                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                           |                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                 |                                                                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)                               |                                                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                                 |                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-4-1969</i> , to <i>2-9-1969</i> , that (I) (we) last saw the deceased alive on <i>2-9-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                              |  |                                                                                                             |                                                                 |                                                                                                                                                             |  |                                                                                                 |                                                                               |
| 22b. SIGNATURE<br><i>Angelita Topacio</i>                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                             |                                                                 | 22c. DATE SIGNED<br><i>2-9-69</i>                                                                                                                           |  | 22d. PHYSICIAN'S NAME (Type)<br><i>ANGELITA TOPACIO</i>                                         |                                                                               |
| 22e. ADDRESS<br><i>BALTO.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                             |                                                                 |                                                                                                                                                             |  |                                                                                                 |                                                                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><i>2-11-69</i>                                                                                 |                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn Cemetery</i>                                                                                              |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                     |                                                                               |
| 24. FUNERAL DIRECTOR<br><i>Marion Armacost-4600 Liberty Hgts. Avenue</i>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                             |                                                                 | 25a. REC'D BY REGISTRAR<br><i>FEB 11 1969</i>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                              |                                                                               |

22030

22030

22030

in

in

in 11 - 11 - 11

Westbury Court

Westbury Court

at the bottom of the page

1-2-3

8-2

Project D. 10900

in 11 - 11 - 11

1-2-3

in 11 - 11 - 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              |  |                                                                                                                                               |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------|--|--|
| 02096                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                                                                               |  | 02092                                                                                                    |  |                                                                                              |                                   |                                                |  |  |
| 1. DECEASED-NAME (Type or print) <b>HAZEL N. PLough</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |  |                                                                                                                                               |  | 2a. DATE OF DEATH <b>2</b> Month <b>13</b> Day <b>69</b> Year                                            |  |                                                                                              |                                   | 2b. HOUR <b>5:00 A M</b>                       |  |  |
| 3. SEX <b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE <b>W</b>                                                             |  | 5. DATE OF BIRTH <b>5/20/1903</b>                                                                                                             |  | 6. AGE (In years lost birthday) <b>65</b> YRS.                                                           |  | IF UNDER 1 YEAR MONTHS OAYS                                                                  |                                   | IF UNDER 24 HRS. HOURS MIN.                    |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.                                                                  |  |                                                                                              |                                   |                                                |  |  |
| 10. CITY OR TOWN OF DEATH <b>CATonsville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>18 BRIARWOOD Ave</b>                                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b> |  |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY |                                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |  | 13b. COUNTY <b>BALTO.</b>                                                                                                                     |  | 13c. CITY OR TOWN <b>CATonsville</b>                                                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER <b>18 BRIARWOOD Ave</b> |  |  |
| 14. FATHER'S NAME First Middle Last <b>EDWARD B. WALTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>MADge Bredemeyer</b>                                                                            |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |  | 16b. SOCIAL SECURITY NO.                                                                                                                      |  | 17. INFORMANT Address <b>RAYMOND F. PLough 18 BRIARWOOD Ave</b>                                          |  |                                                                                              |                                   |                                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic cancer of the liver</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cancer of the breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 m.</b><br><b>4 1/2 y.</b> |  |                                                                              |  |                                                                                                                                               |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>arteriosclerotic cardiovascular disease</b>                                                                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                                                                               |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                                                                                                                               |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                               |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work                                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.                                                                                                            |  | City or Town                                                                                             |  | County                                                                                       |                                   | State                                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-30</b> , 19 <b>63</b> , to <b>2-2</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-2</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                        |  |                                                                              |  |                                                                                                                                               |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
| 22b. SIGNATURE <b>Yu-Chen Lee</b> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              |  | DEGREE                                                                                                                                        |  | ATTENDING PHYS. <input checked="" type="checkbox"/>                                                      |  | MED. DIRECTOR <input type="checkbox"/>                                                       |                                   | STAFF PHYS. <input type="checkbox"/>           |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Yu-Chen LEE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |  | 22e. ADDRESS <b>1206 Frederick Rd. Balto. 21228</b>                                                                                           |  |                                                                                                          |  |                                                                                              |                                   |                                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE <b>2/15/69</b>                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon PK. Cem.</b>                                                                                     |  | 23d. LOCATION (City or Town) <b>BALTO</b>                                                                |  | (County) <b>MD.</b>                                                                          |                                   | (State)                                        |  |  |
| 24. FUNERAL DIRECTOR <b>F.S. MacNabb</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |  | ADDRESS <b>301 Frederick Rd. BALTO. 28 Md.</b>                                                                                                |  | 25a. REC'D BY REGISTRAR                                                                                  |  | 25b. REGISTRAR'S SIGNATURE <b>1911 A. ...</b>                                                |                                   |                                                |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                                                                               |  | DATE <b>FEB 17 1969</b>                                                                                  |  |                                                                                              |                                   |                                                |  |  |

MEDICAL CERTIFICATION





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

02097

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02093

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |                                                                                                 |                                            |                                                                                                                                                                                                                  |  |                                                                                                 |  |                                                                                     |  |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------|--|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print) First Middle Last<br>NICHOLAS Wm. POLITZ                                                                                                                                                                                                                                                                                                                                                                         |                  |                                                                                                 |                                            | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>Feb. 21, 1969                                                                                                                                                       |  |                                                                                                 |  | 2b. HOUR<br>12:40                                                                   |  |                                              |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br>White | 5. DATE OF BIRTH<br>June 7, 1945                                                                | 6. AGE (In years last birthday)<br>23 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>Feb. 21, 1969                         |  | 2d. HOUR<br>12:40                            |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                             |                                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>                                                      |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                                             |  |                                                                                     |  |                                              |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                               |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>East bound #695 |                                            | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Mechanic                                                                                                              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Eng. Mech.                                                 |  |                                                                                     |  |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland                                                                                                                                                                                                                                                                                                                                               |                  | 13b. COUNTY Baltimore                                                                           |                                            | 13c. CITY OR TOWN<br>Joppa                                                                                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>341 Trimble Rd. Apt. 3                                    |  |                                              |
| 14. FATHER'S NAME First Middle Last<br>George F. Politz Sr.                                                                                                                                                                                                                                                                                                                                                                                          |                  |                                                                                                 |                                            | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Cathryn E. Gunther                                                                                                                                                 |  |                                                                                                 |  |                                                                                     |  |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No                                                                                                                                                                                                                                                                                                                                                                          |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>215 42 0095                |                                            | 17. INFORMANT ADDRESS<br>George F. Politz Jr. 1236 Hilldale Avenue                                                                                                                                               |  |                                                                                                 |  |                                                                                     |  |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Traumatic Injuries<br>8150<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                             |                  |                                                                                                 |                                            |                                                                                                                                                                                                                  |  |                                                                                                 |  |                                                                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                  |                  |                                                                                                 |                                            |                                                                                                                                                                                                                  |  |                                                                                                 |  |                                                                                     |  |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                 |                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                                                                                |  |                                                                                                 |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                              |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>12:05xx 2/21/ 1969                         |                                            | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Driver in single car collision                                                                                                |  |                                                                                                 |  |                                                                                     |  |                                              |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Street          |                                            | 21f. LOCATION Street or R.F.D. No.<br>East bound #695                                                                                                                                                            |  | City or Town<br>Balto.                                                                          |  | County<br>M.D.                                                                      |  | State                                        |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |                                                                                                 |                                            |                                                                                                                                                                                                                  |  |                                                                                                 |  |                                                                                     |  |                                              |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Ronald N. Kornblum, M.D.                                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                 |                                            | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |                                                                                                 |  | 22b. DATE SIGNED<br>2/21/69                                                         |  |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                  |                  | 23b. DATE<br>2-24-69                                                                            |                                            | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cemetery                                                                                                                                                  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |                                                                                     |  |                                              |
| 24. FUNERAL DIRECTOR<br>Philip E. Grach                                                                                                                                                                                                                                                                                                                                                                                                              |                  |                                                                                                 |                                            | ADDRESS<br>1211 Chesaco Avenue                                                                                                                                                                                   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>FEB 24 1969                                                  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Quade                                      |  |                                              |

03053

REPORT EXAMINER'S CERTIFICATE OF DESIGN

03053

REPORT EXAMINER'S CERTIFICATE OF DESIGN

REPORT EXAMINER'S CERTIFICATE OF DESIGN

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------|--|--|--------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | First<br><i>Henry</i>                                                                                       |  |  | Middle<br><i>Percival</i>                                                                                                                                   |  |  | Last<br><i>Powell</i>                                                                           |  |  | 2a. DATE OF DEATH<br>Month<br><i>Feb</i> Day<br><i>12</i> Year<br><i>1969</i>    |  |  | 2b. HOUR<br><i>9 P M</i> |  |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 4. RACE<br><i>white</i>                                                                                     |  |  | 5. DATE OF BIRTH<br><i>9-19-83</i>                                                                                                                          |  |  | 6. AGE (In years lost birthday)<br><i>85</i> YRS.                                               |  |  | IF UNDER 1 YEAR<br>MONTHS<br><i>85</i> DAYS<br><i>12</i> HOURS<br><i>12</i> MIN. |  |  |                          |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Jamaica</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>                                                             |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore County</i> Md.                                               |  |  |                                                                                  |  |  |                          |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Mount Wilson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Mt. Wilson St. Hosp.</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Store Manager</i>                                             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |  |                                                                                  |  |  |                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE<br><i>Md</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 13b. COUNTY<br><i>Frederick</i>                                                                             |  |  | 13c. CITY OR TOWN<br><i>Town</i>                                                                                                                            |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><i>Rd. #1 Sabillasville, Md</i>                        |  |  |                          |  |  |
| 14. FATHER'S NAME<br>First<br><i>Horatio W.</i> Middle<br><i>Powell</i> Last<br><i>Allen</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><i>Amanda F.</i> Middle<br><i>Allen</i> Last<br><i>Allen</i>           |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>No</i> (If yes give war or dates of service)                                      |  |  | 16b. SOCIAL SECURITY NO.<br><i>216-09-1108</i>                                                  |  |  | 17. INFORMANT<br><i>Records, Mt. Wilson State Hospital</i> Address               |  |  |                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA &amp; Cor Pulmonale</i><br><i>0119</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Emphysema &amp; BRONCHIECTASIS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>TUBERCULOSIS</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |                          |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                            |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                                                                                  |  |  |                          |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                           |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-8</i> , 19 <i>69</i> , to <i>Feb 12</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2-12</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                |  |  |                                                                                                             |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
| 22b. SIGNATURE<br><i>William Newcomer</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | DEGREE<br><i>M.D.</i>                                                                                       |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><i>2-13-69</i>                                                              |  |  |                                                                                  |  |  |                          |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>William Newcomer, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 22e. ADDRESS<br><i>Mount Wilson, Maryland</i>                                                               |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                  |  |  |                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 23b. DATE<br><i>2/15/69</i>                                                                                 |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Behl</i>                                                                                                           |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Lantz #1, Frederick Co., Md.</i>            |  |  |                                                                                  |  |  |                          |  |  |
| 24. FUNERAL DIRECTOR<br><i>David L. Grove, Waynesboro Pa</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | ADDRESS<br><i>Waynesboro Pa</i>                                                                             |  |  | 25a. RECEIVED BY REGISTRAR<br><i>PEB 17 1969</i>                                                                                                            |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>DATE</i>                                                       |  |  |                                                                                  |  |  |                          |  |  |

Mount Wilson, E. Wilson St., Los Angeles, Cal.

00000000000000000000000000000000

1. **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                            |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              | First                                                                        |                                                                                                                                                          | Middle |                                                                                         | Last |                                                                                   |  |
| RICHARD ALLEN PRELL                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4. RACE | 5. DATE OF BIRTH                                                             |                                                                              | 6. AGE (In years last birthday)                                                                                                                          |        | IF UNDER 1 YEAR                                                                         |      | IF UNDER 24 HRS                                                                   |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                   | White   | 12-10-1968                                                                   |                                                                              | YRS. MONTHS DAYS                                                                                                                                         |        | HOURS MIN.                                                                              |      |                                                                                   |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                              |         | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. COUNTY OF DEATH                                                                      |      | 2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Feb. 7, 1969:25 A.    |  |
| BALTIMORE, MD.                                                                                                                                                                                                                                                                                                                                                                                                                         |         | U.S.A.                                                                       |                                                                              |                                                                                                                                                          |        | Baltimore                                                                               |      |                                                                                   |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |         |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      | 12b. KIND OF BUSINESS OR INDUSTRY                                                 |  |
| Owings Mills                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                              | 10,906 Hunt Cliff Drive                                                      |                                                                                                                                                          |        | NONE                                                                                    |      | NONE                                                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland                                                                                                                                                                                                                                                                                                                                 |         |                                                                              | 13b. COUNTY Baltimore                                                        |                                                                                                                                                          |        | 13c. CITY OR TOWN OWINGS MILLS                                                          |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                          |        | 13e. STREET AND NUMBER                                                                  |      |                                                                                   |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                              | First Middle Last                                                            |                                                                                                                                                          |        | 10,906 Hunt Cliff Drive                                                                 |      |                                                                                   |  |
| ROBERT ALLEN PRELL                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              | JOANNE M. ODROWAS                                                            |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                              | 16b. SOCIAL SECURITY NO. NO                                                  |                                                                                                                                                          |        | 17. INFORMANT ADDRESS MR. ROBERT A. PRELL, 10906 HUNTCLIFF DR.                          |      |                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                              |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| IMMEDIATE CAUSE (a) <u>484X</u> <u>Interstitial Pneumonitis (SDII)</u>                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                    |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                        |        |                                                                                         |      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                       |         |                                                                              |                                                                              | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19                                                                                                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |      |                                                                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                 |         | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) |                                                                              | 21f. LOCATION Street or R.F.D. No.                                                                                                                       |        | City or Town                                                                            |      | County State                                                                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                                                              |                                                                              |                                                                                                                                                          |        |                                                                                         |      |                                                                                   |  |
| ACTUAL SIGNATURE <u>Ronald N. Kornblum</u>                                                                                                                                                                                                                                                                                                                                                                                             |         |                                                                              |                                                                              | M.D.                                                                                                                                                     |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                         |      | 22b. DATE SIGNED 2/7/69                                                           |  |
| EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                              |                                                                              |                                                                                                                                                          |        | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |      |                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                              |                                                                              |                                                                                                                                                          |        | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                        |      |                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |                                                                              |                                                                              |                                                                                                                                                          |        | ADDRESS (Street, city, town, or county)                                                 |      |                                                                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL                                                                                                                                                                                                                                                                                                                                                                                       |         | 23b. DATE 2-9-69                                                             |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)                                                                                              |        | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND                       |      |                                                                                   |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                                                                              |                                                                              | ADDRESS                                                                                                                                                  |        | 25a. REC'D BY REGISTRAR                                                                 |      | 25b. REGISTRAR'S SIGNATURE                                                        |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                                                                                                                                           |         |                                                                              |                                                                              |                                                                                                                                                          |        | DATE FEB 13 1969                                                                        |      | <u>Charles Judge</u>                                                              |  |

OR JAIL  
HEALTH BUREAU



10000

10000

A LOCAL TO BUREAU OF HEALTH

10000 10-1-1953

BALTIMORE, MD. D.C.A.

ROBERT ALLEN FRELL

TOWNE

W. ARNOLD A. FRELL, 10000 INVESTIGATIVE

ARNDT (10000)

CHICK ARNOLD (BALTIMORE)

FEB 13 1959

10000 INVESTIGATIVE ROAD



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                 |                                                                                                         |                                                                                                                                                             |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                 |                                                                                                         |                                                                                                                                                             |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                 | First<br>Edith                                                                                          |                                                                                                                                                             | Middle<br>Peggy                                                 |                                                                                                    | Last<br>RAISOR                                                                                             |                                                                         | 2a. DATE OF DEATH<br>Month 2 Day 1 Year 69   |                                                           |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br>White                                                                |                                                                                                         | 5. DATE OF BIRTH<br>Jan. 24, 1950                                                                                                                           |                                                                 |                                                                                                    | 6. AGE (In years<br>last birthday)<br>19 YRS.                                                              |                                                                         | 2b. HOUR<br>9:45 M                           |                                                           |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                          |                                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                 | 9. COUNTY OF DEATH<br>Baltimore                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rosewood State Hosp. |                                                                                                                                                             |                                                                 | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>none |                                                                                                            |                                                                         | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>none |                                                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before<br>admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                 | 13b. COUNTY<br>Cecil                                                                                    |                                                                                                                                                             | 13c. CITY OR TOWN<br>Conowingo                                  |                                                                                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                         | 13e. STREET AND NUMBER<br>R.R.1              |                                                           |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Charles Samuel RAISOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                 | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Johanna Auguste LORENZ                                 |                                                                                                                                                             |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                 | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>---                                |                                                                                                                                                             | 17. INFORMANT<br>Address<br>Rosewood Records, Owings Mills, Md. |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Orthostatic Neurotoxic Pneumonia</i><br>486X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Institutionalized 6 yrs Chronic brain syndrome, unknown Etiology</i> |  |                                                                                 |                                                                                                         |                                                                                                                                                             |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 week |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                                                                                                         |                                                                                                                                                             |                                                                 | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |                                                                                                            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                              |                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                                                                                                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                                                                                                         | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                 | City or Town                                                                                       |                                                                                                            | County                                                                  |                                              | State                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16, 1963</u> , to <u>Feb. 1, 1969</u> , that (I) (we) lost<br>saw the deceased alive on <u>Feb. 1, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>cause(s) stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                               |  |                                                                                 |                                                                                                         |                                                                                                                                                             |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 22b. SIGNATURE<br><i>Richard A. Jones</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                 |                                                                                                         | DEGREE<br>ATTENDING PHYS.                                                                                                                                   |                                                                 | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>             |                                                                                                            | 22c. DATE SIGNED<br>3 Feb 69                                            |                                              |                                                           |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Richard A. Jones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                 |                                                                                                         | 22e. ADDRESS                                                                                                                                                |                                                                 |                                                                                                    |                                                                                                            |                                                                         |                                              |                                                           |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><u>Feb. 4-69</u>                                                   |                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Conowingo Baptist</u>                                                                                              |                                                                 | 23d. LOCATION (City or Town)<br><u>Conowingo</u>                                                   |                                                                                                            | (County)<br><u>Cecil</u>                                                |                                              | (State)<br><u>Md</u>                                      |  |
| 24. FUNERAL DIRECTOR<br><i>Edmon C. Miller</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                 |                                                                                                         | ADDRESS<br><i>Rising Sun</i>                                                                                                                                |                                                                 | 25a. REC'D BY REGISTRAR<br>DATE<br><u>FEB 5 1969</u>                                               |                                                                                                            | 25b. REGISTRAR'S SIGNATURE<br><i>William S. Jones</i>                   |                                              |                                                           |  |

02030

ORIGINAL OF PAGE

15100

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

58  
03  
1

| <div style="display: flex; justify-content: space-between;"> <span>02101</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>CERTIFICATE OF DEATH</span> <span>02097</span> </div>                                                                                                   |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------|--|--|------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                            |  |  | First<br><b>SADIE</b>                                                                                      |  |  | Middle<br><b>REDEL</b>                                                                                                                                      |  |  | Last                                                                                 |  |  | 2a. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>17</b> Year <b>1969</b> |  |  | 2b. HOUR<br><b>6:00A</b>                       |  |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                        |  |  | 4. RACE<br><b>WHITE</b>                                                                                    |  |  | 5. DATE OF BIRTH<br><b>NOVEMBER 19, 1888</b>                                                                                                                |  |  | 6. AGE (In years lost baby)<br><b>80</b> YRS.                                        |  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                            |  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE,</b> Md.                                          |  |  |                                                                           |  |  |                                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                     |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                                  |  |  |                                                                           |  |  |                                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                               |  |  | 13b. COUNTY<br><b>BALTO</b>                                                                                |  |  | 13c. CITY OR TOWN<br><b>Parkville</b>                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>9000 HARFORD RD. #21234</b>                  |  |  |                                                |  |  |
| 14. FATHER'S NAME<br>First <b>George F</b> Middle <b>Miller</b> Last <b>Miller</b>                                                                                                                                                                                                                                                                                             |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>Schoepfen</b> Last <b>Schoepfen</b>           |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                       |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-50-4180</b>                                                             |  |  | 17. INFORMANT<br><b>Lorraine Redel</b>                                                                                                                      |  |  | Address<br><b>Same</b>                                                               |  |  |                                                                           |  |  |                                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>4270</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |  |                                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Chronic lymphocytic leukemia.</b>                                                                                                                                                                                                    |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |                                                                           |  |  |                                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                       |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                          |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                 |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 7, 1969</b> , to <b>February 17, 1969</b> , that (I) (we) lost saw the deceased alive on <b>February 17, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
| 22b. SIGNATURE<br><b>Lillian</b>                                                                                                                                                                                                                                                                                                                                               |  |  | DEGREE                                                                                                     |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                        |  |  | 22c. DATE SIGNED                                                                     |  |  |                                                                           |  |  |                                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Cillian M.D.</b>                                                                                                                                                                                                                                                                                                                       |  |  | 22e. ADDRESS<br><b>7620 York Rd.</b>                                                                       |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |                                                                           |  |  |                                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                     |  |  | 23b. DATE<br><b>2-20-69</b>                                                                                |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                                                                                              |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Md.</b>                    |  |  |                                                                           |  |  |                                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>C.T. EVANSTON</b>                                                                                                                                                                                                                                                                                                                                   |  |  | ADDRESS<br><b>8802 Harford Rd</b>                                                                          |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 19 1969</b>                                                                                                          |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |                                                                           |  |  |                                                |  |  |

78080

78080

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove record papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02098

02102

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                         |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Austin William REESER</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month Day Year<br><b>FEBRUARY 9 1969</b>                                             |                                                                                                                                 | 2b. HOUR<br><b>8:30AM</b>                                                                  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br><b>White</b>                                                                                                 | 5. DATE OF BIRTH<br><b>10/3/19</b>                                                                                                                          |                                                                                                           | 6. AGE (In years last birthday)<br><b>49</b> YRS.                                                                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN                            |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                |                                                                                                                                 |                                                                                            |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>                                                                                                                                                                                                                                                                                                                                                                                                                | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Administration Hospital</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Manager</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotels</b>                                                                              |                                                                                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                               | 13b. COUNTY<br><b>Baltimore</b>                                                                                         | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 13e. STREET AND NUMBER<br><b>2137 Maryland Avenue</b>                                                                           |                                                                                            |
| 14. FATHER'S NAME First Middle Last<br><b>Fred Reeser</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                         | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Carrie Klaunberg</b>                                                                                       |                                                                                                           |                                                                                                                                 |                                                                                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>                                                                                                                                                                                                                                                                                                                                 |                                                                                                                         | 16b. SOCIAL SECURITY NO.<br><b>213 14 8052</b>                                                                                                              |                                                                                                           | 17. INFORMANT Address<br><b>Clin. Rec. VAH, Fort Howard, Maryland</b>                                                           |                                                                                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ARTERIOSCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>BRONCHO PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BRONCHO PNEUMONIA</b> |                                                                                                                         |                                                                                                                                                             |                                                                                                           |                                                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YEARS</b><br><b>DAYS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                                             |                                                                                                                         |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                                            |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                           | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                       |                                                                                                                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                                                  |                                                                                                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                 |                                                                                            |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |                                                                                                           | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                    |                                                                                            |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>Jan. 9</b> , 19 <b>69</b> , to <b>Feb. 9</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>Feb. 9</b> , 19 <b>69</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (did not) view the body after death.                                                                                         |                                                                                                                         |                                                                                                                                                             |                                                                                                           |                                                                                                                                 |                                                                                            |
| 22b. SIGNATURE<br><b>Madhav D. Barhanpurkar</b> DEGREE                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         |                                                                                                                                                             |                                                                                                           | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>2/9/69</b>                                                          |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV D. BARHANPURKAR, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                         | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>                                                                                                   |                                                                                                           |                                                                                                                                 |                                                                                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                     | 23b. DATE<br><b>2/13/69</b>                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>                                                                                             | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                               |                                                                                                                                 |                                                                                            |
| 24. FUNERAL DIRECTOR<br><b>Joseph J. Zannino</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                         | 25a. REC'D BY REGISTRAR<br><b>FEB 11 1969</b>                                                                                                               | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                                        |                                                                                                                                 |                                                                                            |

100

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| 1. DECEASED-NAME<br>(Type or print) <b>AUGUST</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                              | First <b>W.</b> Middle <b>Reich</b> Last                                                                    |                                                                                                                                                             |                                                                           | 2a. DATE OF DEATH<br>2 Month 8 Day 69 Year                                                                                             |                                                                                                 | 2b. HOUR<br>4:30 P.M.                              |                                                                |  |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>W</b>                                                          |                                                                                                             | 5. DATE OF BIRTH<br>6/1/1885                                                                                                                                |                                                                           | 6. AGE (In years<br>lost birthday)<br>83 YRS.                                                                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |                                                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Md</b>                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                 |                                                                                                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                           | 9. COUNTY OF DEATH<br><b>BALTO.</b>                                                                                                    |                                                                                                 |                                                    |                                                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>434 Ingleside Ave</b> |                                                                                                                                                             |                                                                           | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>CONTRACTOR</b>                        |                                                                                                 | 12b. KIND OF BUSINESS OR<br>INDUSTRY               |                                                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md</b>                                                                                                                                                                                                                                                                                     |  |                                                                              | 13b. COUNTY <b>BALTO.</b>                                                                                   |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>                                   |                                                                                                                                        | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                    | 13e. STREET AND NUMBER<br><b>434 Ingleside Ave.</b>            |  |
| 14. FATHER'S NAME<br>First <b>HENRY</b> Middle <b>Reich</b> Last                                                                                                                                                                                                                                                                                                                               |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First <b>MARGARET</b> Middle Last                                               |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                           |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>218-32-0778A</b>                                                             |                                                                                                                                                             | 17. INFORMANT<br><b>AMANDA A. Reich</b>                                   |                                                                                                                                        | Address<br><b>434 Ingleside Ave.</b>                                                            |                                                    |                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs +</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                             |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                             |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                                                        | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                                    |                                                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                             | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                           | City or Town                                                                                                                           |                                                                                                 | County State                                       |                                                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1953</b> , to <b>Feb. 8, 1969</b> , that (I) (we) last saw the deceased alive on <b>1-21-69</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                     |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| 22b. SIGNATURE<br><b>John A. Nesbitt, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |                                                                                                             |                                                                                                                                                             |                                                                           | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                                 | 22c. DATE SIGNED<br><b>2-10-69</b>                 |                                                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John A. Nesbitt, Jr., M.D.</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                             | 22e. ADDRESS<br><b>1009 Frederick Road</b>                                                                                                                  |                                                                           |                                                                                                                                        |                                                                                                 |                                                    |                                                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br><b>2/11/69</b>                                                  |                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WOODLAWN CEM.</b>                                                                                                  |                                                                           | 23d. LOCATION (City or Town) (County) (State)<br><b>WOODLAWN BALTO Md</b>                                                              |                                                                                                 |                                                    |                                                                |  |
| 24. FUNERAL DIRECTOR<br><b>E. S. MacNabb</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                                                                                                             | ADDRESS<br><b>301 Frederick Rd Balto Md 28</b>                                                                                                              |                                                                           | 25a. REC'D BY REGISTRAR<br><b>DATE FEB 13 1969</b>                                                                                     |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |                                                                |  |

MEDICAL CERTIFICATION

RECEIVED

10/1/54

10/1/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                 |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|-----------------------------------|-----------------------|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                 |  | First                                                                        |  | Middle                                                                          |  | Last                                                                                    |  | 2a. DATE OF DEATH                                                    |                                   |                       | 2b. HOUR |
| Sr.                                                                                                                                                                                                                                                                                                                 |  | Mary                                                                         |  | David                                                                           |  | Reisch                                                                                  |  | Month 2 Day 7 Year 69                                                |                                   |                       | M        |
| 3. SEX                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                |  |                                                                                         |  | 6. AGE (In years last birthday)                                      |                                   | IF UNDER 1 YEAR       |          |
| Female                                                                                                                                                                                                                                                                                                              |  | White                                                                        |  | 2-21-1894                                                                       |  |                                                                                         |  | 74 YRS.                                                              |                                   | MONTHS DAYS HOURS MIN |          |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED                                                                      |  | NEVER MARRIED                                                                           |  | 9. COUNTY OF DEATH                                                   |                                   |                       |          |
| New York                                                                                                                                                                                                                                                                                                            |  | U. S. A.                                                                     |  | WIDOWED                                                                         |  | DIVORCED                                                                                |  | Baltimore Md.                                                        |                                   |                       |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                                                                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY |                       |          |
| Glen Arm                                                                                                                                                                                                                                                                                                            |  | Glen Arm Rd.                                                                 |  |                                                                                 |  | Teacher                                                                                 |  |                                                                      | EDUCATION                         |                       |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE                                                                                                                                                                                                                       |  | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                               |  | 13d. INSIDE CITY LIMITS?                                                                |  | 13e. STREET AND NUMBER                                               |                                   |                       |          |
| Md.                                                                                                                                                                                                                                                                                                                 |  | Baltimore                                                                    |  |                                                                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | Glen Arm, Md.                                                        |                                   |                       |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                   |  | First                                                                        |  | Middle                                                                          |  | Last                                                                                    |  | 15. MOTHER'S MAIDEN NAME                                             |                                   | First Middle Last     |          |
| Michael                                                                                                                                                                                                                                                                                                             |  | Reisch                                                                       |  | Emilie                                                                          |  | Rousselot                                                                               |  |                                                                      |                                   |                       |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO.                                                     |  | 17. INFORMANT                                                                   |  | Address                                                                                 |  |                                                                      |                                   |                       |          |
| No                                                                                                                                                                                                                                                                                                                  |  | 218-54-4233                                                                  |  | Sr. M. Kathleen                                                                 |  | Glen Arm Md.                                                                            |  |                                                                      |                                   |                       |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                           |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                        |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| IMMEDIATE CAUSE (a) Coronary occlusion & Congestive Heart Failure                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                      |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| (b) Bronchectasis & Löffler's Syndrome                                                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                      |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| (c) Past Hx of Old TBC & Epilepsy                                                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                  |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                                                                 |  | 20a. AUTOPSY?                                                                           |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |                       |          |
|                                                                                                                                                                                                                                                                                                                     |  |                                                                              |  |                                                                                 |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  |                                                                      |                                   |                       |          |
| 21a. ACCIDENT WAS UNDERLYING                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY                                                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |                                                                                         |  |                                                                      |                                   |                       |          |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                               |  | HOUR A.M. Month Day Year P.M. 19                                             |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION                                                                   |  | Street or R.F.D. No.                                                                    |  | City or Town                                                         |                                   | County State          |          |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                 |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1968, to February 1968, that (I) (we) last saw the deceased alive on November 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                              |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                      |  | 22c. DATE, SIGNED                                                            |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| Henry P. Corkle MD                                                                                                                                                                                                                                                                                                  |  | 2/7/69                                                                       |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                        |  | 22e. ADDRESS                                                                 |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| Henry P. MC CORKLE MD                                                                                                                                                                                                                                                                                               |  | Phoenix, Maryland 21131                                                      |  |                                                                                 |  |                                                                                         |  |                                                                      |                                   |                       |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                           |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                              |  | 23d. LOCATION (City or Town)                                                            |  | (County)                                                             |                                   | (State)               |          |
| Burial                                                                                                                                                                                                                                                                                                              |  | 2-10-69                                                                      |  | SISTERS CEMETERY                                                                |  | Glen Arm, Balt.                                                                         |  | Maryland                                                             |                                   |                       |          |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                |  | 25a. REC'D BY REGISTRAR                                                      |  |                                                                                 |  | 25b. REGISTRAR'S SIGNATURE                                                              |  |                                                                      |                                   |                       |          |
| RAYMOND J. CURRAN                                                                                                                                                                                                                                                                                                   |  | 517 S. CARLETT DR. JOWSON, MD 21204                                          |  |                                                                                 |  | DATE FEB 10 1969                                                                        |  | Charles Judge                                                        |                                   |                       |          |

00120

00120

00120

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are faintly visible.]*

REPRODUCTION OF DOCUMENTS FROM THE NATIONAL ARCHIVES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02105

CERTIFICATE OF DEATH

02101

|                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------|------------|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                   |  | First                                                                        | Middle | Last                                                                                                                                                        | 2a. DATE OF DEATH<br>Month Day Year |                                                                                                 | 2b. HOUR A |                                              |
| MARIA                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |        | RITTER                                                                                                                                                      | February 21, 1969                   |                                                                                                 | 5:30 M     |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                      |        | 5. DATE OF BIRTH                                                                                                                                            |                                     | 6. AGE (In years lost birthday)                                                                 |            | IF UNDER 1 YEAR<br>MONTHS DAYS               |
| Female                                                                                                                                                                                                                                                                                                                                                                                                |  | White                                                                        |        | January 20, 1887                                                                                                                                            |                                     | 82 YRS.                                                                                         |            | IF UNDER 24 HRS.<br>HOURS MIN                |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH                                                                              |            |                                              |
| Germany                                                                                                                                                                                                                                                                                                                                                                                               |  | U.S.A.                                                                       |        |                                                                                                                                                             |                                     | Baltimore Md.                                                                                   |            |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                     |                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |            |                                              |
| Towson                                                                                                                                                                                                                                                                                                                                                                                                |  | St. Joseph Hospital                                                          |        | Homemaker                                                                                                                                                   |                                     |                                                                                                 |            |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY                                                                  |        | 13c. CITY OR TOWN                                                                                                                                           |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            | 13e. STREET AND NUMBER                       |
| STATE Maryland                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |        | Baltimore                                                                                                                                                   |                                     |                                                                                                 |            | 4214 Powell Ave. 21206                       |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME                                                     |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                                                     |  | First Middle Last                                                            |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| Joseph Musser                                                                                                                                                                                                                                                                                                                                                                                         |  | Elizabeth Musser                                                             |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.                                                     |        | 17. INFORMANT Address                                                                                                                                       |                                     |                                                                                                 |            |                                              |
| No                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |        | Mrs. Elizabeth Hentze - 4205 Parkmont Ave. - 21206                                                                                                          |                                     |                                                                                                 |            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Generalized purulent peritonitis<br>444.2 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) intestinal infarction with multiple perforations<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                              |        |                                                                                                                                                             |                                     |                                                                                                 |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                    |  |                                                                              |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |            |                                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                     |                                                                                                 |            |                                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                     |                                                                                                 |            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from February 20, 1969, to Feb. 21, 1969, that (I) (we) last saw the deceased alive on February 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                      |  |                                                                              |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                        |  | 22c. DATE SIGNED                                                             |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| Ines Cilliani, M.D.                                                                                                                                                                                                                                                                                                                                                                                   |  | 2-21-69                                                                      |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                          |  | 22e. ADDRESS                                                                 |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| Ines Cilliani, M.D.                                                                                                                                                                                                                                                                                                                                                                                   |  | 7620 York Road, Towson, Md. 21204                                            |        |                                                                                                                                                             |                                     |                                                                                                 |            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                    |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                     | 23d. LOCATION (City or Town) (County) (State)                                                   |            |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                |  | 2-24-69                                                                      |        | Parkwood Cemetery                                                                                                                                           |                                     | Baltimore, Maryland                                                                             |            |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                      |        | 25a. REC'D BY REGISTRAR                                                                                                                                     |                                     | 25b. REGISTRAR'S SIGNATURE                                                                      |            |                                              |
| John C. Miller Inc-6415 Belair Road                                                                                                                                                                                                                                                                                                                                                                   |  | 21206                                                                        |        | DATE FEB 25 1969                                                                                                                                            |                                     | Blanchard Judge                                                                                 |            |                                              |

10180

10180

10180

10180

10180

10180

10180

10180

10180

10180



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                         |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                 |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 02106                                                                                                                                                                                                                                                                                                       |  |                              |                                                                              |                                                                                                                                                          | 02102                                                                                                                                  |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                            |  |                              |                                                                              |                                                                                                                                                          | 2a. DATE OF DEATH                                                                                                                      |                                                                                         |                                                                                              | 2b. HOUR                                                             |                                              |  |
| First Helen Middle S Last Robel                                                                                                                                                                                                                                                                             |  |                              |                                                                              |                                                                                                                                                          | Month February Day 23 Year 69                                                                                                          |                                                                                         |                                                                                              | 8.20PM                                                               |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                      |  | 4. RACE                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                        | 6. AGE (In years lost birthday)                                                         |                                                                                              | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN               |                                              |  |
| Female                                                                                                                                                                                                                                                                                                      |  | White                        |                                                                              | 6-14-98                                                                                                                                                  |                                                                                                                                        | 70 YRS.                                                                                 |                                                                                              |                                                                      |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH                                                                      |                                                                                              |                                                                      |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                                    |  | U.S.A.                       |                                                                              |                                                                                                                                                          |                                                                                                                                        | Baltimore, Md.                                                                          |                                                                                              |                                                                      |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                              |  |
| Towson                                                                                                                                                                                                                                                                                                      |  |                              | St. Joseph Hospital                                                          |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                               |  |                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                                                                                      |                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER                       |  |
| Maryland                                                                                                                                                                                                                                                                                                    |  |                              | Baltimore                                                                    |                                                                                                                                                          | Parkville                                                                                                                              |                                                                                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                                                      | 8714 Maravoss Lane-21234                     |  |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                         |  |                              |                                                                              |                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME First Middle Last                                                                                             |                                                                                         |                                                                                              |                                                                      |                                              |  |
| William Robel                                                                                                                                                                                                                                                                                               |  |                              |                                                                              |                                                                                                                                                          | Margaret ? ?                                                                                                                           |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)                                                                                                                                                                                                    |  |                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT                                                                                                                          |                                                                                         | Address                                                                                      |                                                                      |                                              |  |
| No                                                                                                                                                                                                                                                                                                          |  |                              | None                                                                         |                                                                                                                                                          | George B Witt                                                                                                                          |                                                                                         | Same                                                                                         |                                                                      |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                   |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema                                                                                                                                                                                                                                            |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure.                                                                                                                                                                                                                                           |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD with myocardial infarction.                                                                                                                                         |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                          |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                      |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                                                          |                                                                                                                                        | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |                                                                                              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                          |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                                                                                                          |                                                                                                                                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                                                                              |                                                                      |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>                                                                                                                                                    |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                                                                          |                                                                                                                                        | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                                                                              |                                                                      |                                              |  |
| 22a. I certify that (A) (this hospital) attended the deceased from 2-3-1969, to 2-23-1969, that (A) (we) last saw the deceased alive on 2-23-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 22b. SIGNATURE Christiana Feliciano, M.D.                                                                                                                                                                                                                                                                   |  |                              |                                                                              |                                                                                                                                                          | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                                                                         | 22c. DATE SIGNED February 24, 1969                                                           |                                                                      |                                              |  |
| 22d. PHYSICIAN'S NAME (Type) Christiana Feliciano, M.D.                                                                                                                                                                                                                                                     |  |                              |                                                                              |                                                                                                                                                          | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204                                                                                          |                                                                                         |                                                                                              |                                                                      |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                   |  | 23b. DATE                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                                                                        |                                                                                         | 23d. LOCATION (City or Town) (County) (State)                                                |                                                                      |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                      |  | 2/26/69                      |                                                                              | Holy Redeemer                                                                                                                                            |                                                                                                                                        |                                                                                         | Baltimore Maryland                                                                           |                                                                      |                                              |  |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                |  |                              |                                                                              |                                                                                                                                                          | 25a. REC'D BY REGISTRAR                                                                                                                |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                                                   |                                                                      |                                              |  |
| Leonard J Ruck Inc Baltimore, Maryland                                                                                                                                                                                                                                                                      |  |                              |                                                                              |                                                                                                                                                          | FEB 24 1969                                                                                                                            |                                                                                         | Charles Judge                                                                                |                                                                      |                                              |  |

20130

UNITED STATES DEPARTMENT OF JUSTICE

20130

RECEIVED  
FEB 11 1964  
U.S. DEPT. OF JUSTICE

Division of

of

1964

1964

FEB 11 1964

RECEIVED

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 02107                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  | 02103                                     |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------|--|--------------------------|--|-------------------------------------------|--|--------------------------|--|-------|--|----------|--|---------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                              |  | First                                                                           |  | Middle                                                                                     |  | Last                                                     |  |                          |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |  | Month                    |  | Day   |  | Year     |  | 2b. HOUR                                                                        |  |                                                                                 |  |                              |  |
| HAROLD                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | S.                                                                              |  | ROBINSON                                                                                   |  |                                                          |  |                          |  | 2                                         |  | 18                       |  | 1969  |  | 9:30p    |  |                                                                                 |  |                                                                                 |  |                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE                                                                         |  | 5. DATE OF BIRTH                                                                           |  | 6. AGE (In years<br>last birthday)                       |  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS.                          |  | 2c. DATE PRONOUNCED DEAD |  | Month |  | Day      |  | Year                                                                            |  |                                                                                 |  |                              |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | White                                                                           |  | June 5, 1895                                                                               |  | 73 7/8 HRS.                                              |  | MONTHS                   |  | DAYS                                      |  | HOURS                    |  | MIN.  |  | February |  | 18                                                                              |  |                                                                                 |  |                              |  |
| 7a. BIRTHPLACE (State or foreign<br>country)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?                                                    |  | 8. MARRIED                                                                                 |  | NEVER MARRIED                                            |  | WIDOWED                  |  | DIVORCED                                  |  | 9. COUNTY OF DEATH       |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | U.S.A.                                                                          |  |                                                                                            |  |                                                          |  |                          |  |                                           |  | Balto.                   |  |       |  |          |  | Md.                                                                             |  |                                                                                 |  |                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                     |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| Essex                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 564 Sue Grove Rd.                                                               |  | Management                                                                                 |  | Insurance                                                |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE                                                                                                                                                                                                                                                                                                                                                 |  | 13b. COUNTY                                                                     |  | 13c. CITY OR TOWN                                                                          |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET AND NUMBER   |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Balto.                                                                          |  | Essex                                                                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 564 Sue Grove Rd.        |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                |  | First                                                                           |  | Middle                                                                                     |  | Last                                                     |  | 15. MOTHER'S MAIDEN NAME |  | First                                     |  | Middle                   |  | Last  |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| Joseph Jacob                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Robinson                                                                        |  |                                                                                            |  |                                                          |  | Miriam Joy               |  | Spamer                                    |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO.                                                        |  | 17. INFORMANT                                                                              |  | ADDRESS                                                  |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| Yes                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | W.W. One                                                                        |  | 060-01-1498                                                                                |  | Thomas H. Robinson, Monkton, Maryland                    |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                 |  |                                                                                 |  |                              |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| (b)                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                              |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  | 20. AUTOPSY?                                                                    |  |                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |                              |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |                              |  |
| CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | 19                                                                              |  |                                                                                 |  |                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.                                              |  |                              |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  | City or Town                                                                    |  |                              |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  | County                                                                          |  |                              |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  |                                                                                 |  |                              |  |
| ACTUAL<br>SIGNATURE <u>Edward F. Wilson</u>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | M.D.                                                                            |  | 22b. DATE SIGNED                                                                |  |                              |  |
| EXAMINER'S<br>NAME (Type) <u>Edward F. Wilson, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  |                                                                                 |  | 2/19/69                                                                         |  |                              |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | 23b. DATE                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY                                              |  | 23d. LOCATION (City or Town) |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | Feb. 21, 1969                                                                   |  | Foster Cemetery                                                                 |  | Hereford, Md.                |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | ADDRESS                                                                         |  | 25a. REC'D BY REGISTRAR                                                         |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Wm. Cook-Brooks Towson, 1050 York Road                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                 |  |                                                                                            |  |                                                          |  |                          |  |                                           |  |                          |  |       |  |          |  | Towson, Maryland 21204                                                          |  | FEB 20 1969                                                                     |  | Charles Judge                |  |

90154

00-00000

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------|--|--------------|----------------------------------|--------------|--|---------------------------------------------------|--|---------------------------------------------|--|-------------------------------------------|--|----------------------------------------------------|--|---------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                             |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                     |  |  | First<br>HOWARD                                                                                        |  |  | Middle<br>EARL                                                                                                                                              |  |  | Last<br>ROCKETTE, SR.                                                                           |  |  | 2a. DATE OF DEATH<br>Month<br>FEBRUARY            |  | 19 Day<br>19 |                                  | Year<br>1969 |  | 2b. HOUR<br>12:10                                 |  | A.M.                                        |  |                                           |  |                                                    |  |                                       |  |
| 3. SEX<br>MALE                                                                                                                                                                                                                                                                                                                          |  |  | 4. RACE<br>WHITE                                                                                       |  |  | 5. DATE OF BIRTH<br>JULY 31, 1920                                                                                                                           |  |  | 6. AGE (In years<br>lost birthday)<br>48 YRS.                                                   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                 |  |              | IF UNDER 24 HRS.<br>HOURS<br>MIN |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MARYLAND                                                                                                                                                                                                                                                                                |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                 |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE,                                                                |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON                                                                                                                                                                                                                                                                                                     |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>ST. JOSEPH HOSPITAL |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>MECHANIC                                                      |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>MARTIN CO.                                              |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission)<br>STATE<br>MARYLAND                                                                                                                                                                                                                         |  |  | 13b. COUNTY<br>BALTIMORE                                                                               |  |  | 13c. CITY OR TOWN                                                                                                                                           |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>3211 HISS AVENUE #21234 |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 14. FATHER'S NAME<br>First<br>THOMAS                                                                                                                                                                                                                                                                                                    |  |  | Middle<br>ROCKETTE                                                                                     |  |  | Last                                                                                                                                                        |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>IDA                                                        |  |  | Middle<br>FASTNER                                 |  |              | Last                             |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>(If yes give war or dates of service)                                                                                                                                                                                                                          |  |  | 16b. SOCIAL SECURITY NO.                                                                               |  |  | 17. INFORMANT<br>Mrs. Edith E. Rockette - 3211 Hiss Ave.                                                                                                    |  |  | Address                                                                                         |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                               |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 428X DUE TO <u>myocarditis.</u>                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.                                                                                                                                                                                                                                 |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| (c)                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                      |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                             |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                            |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 8, 1969, to February 19, 1969, that I (we) lost<br>saw the deceased alive on February 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 22b. SIGNATURE<br>William M.D.                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  | DEGREE                                            |  | ATTENDING<br>PHYS. <input type="checkbox"/> |  | MED.<br>DIRECTOR <input type="checkbox"/> |  | STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>February 19, 1969 |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Ines Cilliani, M.D.                                                                                                                                                                                                                                                                                  |  |  |                                                                                                        |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                   |  |              |                                  |              |  | 22e. ADDRESS<br>7620 York Road, Towson, Md. 21204 |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                  |  |  | 23b. DATE<br>2-22-69                                                                                   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH CEM.                                                                                                 |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO. MD.                                     |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>J. J. Miller - 2334                                                                                                                                                                                                                                                                                             |  |  | ADDRESS<br>Jefferson St.                                                                               |  |  | 25a. REC'D BY REGISTRAR<br>FEB 24 1969                                                                                                                      |  |  | 25b. REGISTRAR'S SIGNATURE<br>J. Charles Jones                                                  |  |  |                                                   |  |              |                                  |              |  |                                                   |  |                                             |  |                                           |  |                                                    |  |                                       |  |

2010

RECEIVED

2010



1

FEB 10 2010



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

70  
03  
1

2

VR A15  
30M REV. 1-64

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02109

02105

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                 |                                                                                 |                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Edna</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |  | First <b>Edna</b> Middle <b>May</b> Last <b>Rohde</b>                                                              |  |  | 2a. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>16</b> Year <b>1969</b>                                                                                       |  |  | 2b. HOUR <b>12:45</b> P.M.                                                                      |                                                                                 |                                                    |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | 4. RACE<br><b>White</b>                                                                                            |  |  | 5. DATE OF BIRTH<br><b>June 19, 1887</b>                                                                                                                    |  |  | 6. AGE (In years last birthday)<br><b>81</b> YRS.                                               |                                                                                 |                                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                         |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                      |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.                                               |                                                                                 |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Dulaney-Towson Nursing Home</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                                 |                                                                                 |                                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                 |  |  | 13b. CITY<br><b>Baltimore</b>                                                                                      |  |  | 13c. CITY OR TOWN<br><b>Reisterstown</b>                                                                                                                    |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                 |                                                    |  |
| 13e. STREET AND NUMBER<br><b>17 Aldyth Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                |  |  | 14. FATHER'S NAME First <b>Harmon</b> Middle <b>K.</b> Last <b>Wells</b>                                           |  |  | 15. MOTHER'S MAIDEN NAME First <b>Laura</b> Middle <b>P.</b> Last <b>Gridley</b>                                                                            |  |  |                                                                                                 |                                                                                 |                                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>                                                                                                                                                                                                                                                                                                                                                  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-01-6381</b>                                                                     |  |  | 17. INFORMANT<br><b>Mrs. Elizabeth Wheeler Glyndon, Md.</b>                                                                                                 |  |  | Address <b>Louquecker Rd.</b>                                                                   |                                                                                 |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Congestion- Bronchial Pneumonia</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic C-V Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks.</b><br><b>10 yrs.</b> |                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                               |  |  |                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                 |                                                                                 |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                                                                 |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)<br><b>None</b>                                                                                                                                                                                                                                                             |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |                                                                                 |                                                    |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |                                                                                 |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-18-68</b> , 19__, to <b>2-16-69</b> , 19__, that (I) (we) last saw the deceased alive on <b>2-15-69</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                |  |  |                                                                                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                 |                                                                                 |                                                    |  |
| 22b. SIGNATURE<br><b>D. D. Caples</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                                    |  |  |                                                                                                                                                             |  |  | 22c. DATE SIGNED<br><b>2-17-69</b>                                                              |                                                                                 |                                                    |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>D. D. Caples, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                                                                    |  |  | 22e. ADDRESS<br><b>6 Hanover Rd., Reisterstown, Md. 21136</b>                                                                                               |  |  |                                                                                                 |                                                                                 |                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                       |  |  | 23b. DATE<br><b>Feb. 19, 1969</b>                                                                                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cem.</b>                                                                                               |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Balto., Md.</b>                  |                                                                                 |                                                    |  |
| 24. FUNERAL DIRECTOR<br><b>H. J. Schardt</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                                    |  |  | ADDRESS<br><b>Owings Mills, Md.</b>                                                                                                                         |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 20 1969</b>                                              |                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

MEDICAL CERTIFICATION

I

I

I

I

I

I

I

I

I

I

I

I

I

I

I

I

I

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                          |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------|------------------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                  |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                         |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 1. DECEASED-NAME (Type or print) <i>Nellie</i> First Middle Last <i>Rosier</i>                                                                                                                                                                                                                                                                                                               |  |                                            |                                                                                                              |                                                                                                                                                          |  | 2a. DATE OF DEATH Month <i>February</i> Day <i>21</i> Year <i>1969</i>                                  |                                                  |                                                                                 | 2b. HOUR <i>5:30 P.M.</i>                                                                    |                                                                      |                             |                                                |  |  |
| 3. SEX <i>F</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE <i>Caucasian</i>                   |                                                                                                              | 5. DATE OF BIRTH <i>March 12, 1883</i>                                                                                                                   |  |                                                                                                         | 6. AGE (In years lost (birthday)) <i>85</i> YRS. |                                                                                 | IF UNDER 4 YEAR MONTHS DAYS                                                                  |                                                                      | IF UNDER 24 HRS. HOURS MIN. |                                                |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Md.</i>                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |                                                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore, Md.</i>                                                                |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 10. CITY OR TOWN OF DEATH <i>Parkton</i>                                                                                                                                                                                                                                                                                                                                                     |  |                                            | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Cameron Mill Rd. Parkton</i> |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Caporese</i> |                                                  |                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY <i>Canning</i>                                             |                                                                      |                             |                                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>                                                                                                                                                                                                                                                                                     |  |                                            | 13b. COUNTY <i>Baltimore</i>                                                                                 |                                                                                                                                                          |  | 13c. CITY OR TOWN <i>Parkton</i>                                                                        |                                                  |                                                                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                      |                             | 13e. STREET AND NUMBER <i>Cameron Mill Rd.</i> |  |  |
| 14. FATHER'S NAME First Middle Last <i>Unknown</i>                                                                                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                              |                                                                                                                                                          |  | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Dorcas Ann Rosier</i>                                     |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)                                                                                                                                                                                                                                                                           |  |                                            |                                                                                                              | 16b. SOCIAL SECURITY NO. <i>179-209230M</i>                                                                                                              |  | 17. INFORMANT <i>Minnie R. Rosier, Parkton, Md-21120.</i> Address                                       |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                    |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                 |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| IMMEDIATE CAUSE (a) <i>C. S. C. V. disease</i>                                                                                                                                                                                                                                                                                                                                               |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 4124 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                          |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                            |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                          |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                           |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                       |  |                                            |                                                                                                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                         |  |                                                                                                         |                                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |                                                                                              | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |                                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                           |  |                                            |                                                                                                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>                                                                                              |  |                                                                                                         |                                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                                              |                                                                      |                             |                                                |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                      |  |                                            |                                                                                                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                             |  |                                                                                                         |                                                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                                              |                                                                      |                             |                                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1940</i> , to <i>2/21/69</i> , 19 <i>19</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>1/21/69</i> , 19 <i>19</i> , and that in <i>(my) (our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death. |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 22b. SIGNATURE <i>A. M. France</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                                    |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  | 22c. DATE SIGNED <i>2/21/69</i>                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>                                                                                                                                                                                                                                                                                                                                             |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  | 22e. ADDRESS <i>PARKTON, MD</i>                                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>                                                                                                                                                                                                                                                                                                                                      |  |                                            |                                                                                                              | 23b. DATE <i>Febr. 24/1969</i>                                                                                                                           |  | 23c. NAME OF CEMETERY OR CREMATORY <i>West Liberty Cem</i>                                              |                                                  |                                                                                 |                                                                                              | 23d. LOCATION (City or Town) (County) (State) <i>White Hall Md</i>   |                             |                                                |  |  |
| 24. FUNERAL DIRECTOR <i>James Harkenstein, New Freedom Pa.</i>                                                                                                                                                                                                                                                                                                                               |  |                                            |                                                                                                              | 25a. REC'D BY REGISTRAR <i>Charles Judge</i>                                                                                                             |  |                                                                                                         |                                                  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                 |                                                                                              |                                                                      |                             |                                                |  |  |
| DATE <i>FEB 25 1969</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                            |                                                                                                              |                                                                                                                                                          |  |                                                                                                         |                                                  |                                                                                 |                                                                                              |                                                                      |                             |                                                |  |  |

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

*[Faint, illegible text in the right margin, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/8

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                             |  |  | First<br><b>Mary</b>                                                                                       |  |  | Middle<br><b>F.</b>                                                                                                                                         |  |  | Last<br><b>Russell</b>                                                                          |  |  | 2a. DATE OF DEATH<br>Month<br><b>February</b> Day<br><b>18</b> Year<br><b>1969</b> |  |                                                                                                                     | 2b. HOUR<br><b>10:50</b> AM                           |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                         |  |  | 4. RACE<br><b>White</b>                                                                                    |  |  | 5. DATE OF BIRTH<br><b>4-4-1898</b>                                                                                                                         |  |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.                                               |  |  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b> DAYS<br><b>0</b>                             |  |                                                                                                                     | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN<br><b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Indiana</b>                                                                                                                                                                                                                                                                                                                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                 |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                          |  |  | Md.                                                                                |  |                                                                                                                     |                                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                      |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                |  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                            |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>7906 Elmhurst Ave. #21234</b>                         |  |                                                                                                                     |                                                       |  |  |
| 14. FATHER'S NAME<br>First<br><b>John</b> Middle<br><b>P.</b> Last<br><b>Lambert</b>                                                                                                                                                                                                                                                                                            |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Della</b> Middle<br><b>Gregory</b> Last<br><b>Gregory</b>          |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)<br><b>No</b>                                                                           |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-05-2909B</b>                                                 |  |  | 17. INFORMANT<br><b>Mr. Raymond W. Russell</b> Address<br><b>(Same)</b>            |  |                                                                                                                     |                                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized peritonitis.</b><br><b>567.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |  |                                                                                                                     |                                                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                              |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                          |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                        |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                 |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <b>February 8, 1969</b> , to <b>February 18, 1969</b> , that (A) (we) last saw the deceased alive on <b>February 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                     |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 22b. SIGNATURE<br><br>DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                 |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | 22c. DATE SIGNED<br><b>February 18, 1969</b>                                       |  |                                                                                                                     |                                                       |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M.D.</b>                                                                                                                                                                                                                                                                                                             |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | 22e. ADDRESS<br><b>7620 York Road, Towson, Md. 21204</b>                           |  |                                                                                                                     |                                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                      |  |  | 23b. DATE<br><b>2/21/69.</b>                                                                               |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Mausoleum</b>                                                                                    |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                          |  |  |                                                                                    |  |                                                                                                                     |                                                       |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 19 1969</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br> |                                                       |  |  |

02180

02180

02180

02180

02180

02180

02180

02180

02180

02180

02180

02180

02180



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02112</div> <div> <div>1</div> <div>02108</div> </div>                                                                                                                                                                                                                                                                                                           |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------|---------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |                              |                                                                                 |  | 2a. DATE OF DEATH                                                                                                                                        |                                 |                                                                                         | 2b. HOUR              |                                                                                        |                                              |
| <div>First Middle Last</div> <div>Frank Casmer RUZAKOWSKI</div>                                                                                                                                                                                                                                                                                                       |  |                                                                              |                              |                                                                                 |  | <div>Month Day Year</div> <div>2 11 1969</div>                                                                                                           |                                 |                                                                                         | <div>8 A M</div>      |                                                                                        |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                      |                              | 5. DATE OF BIRTH                                                                |  |                                                                                                                                                          | 6. AGE (In years last birthday) |                                                                                         | IF UNDER 1 YEAR       |                                                                                        | IF UNDER 24 HRS.                             |
| Male                                                                                                                                                                                                                                                                                                                                                                  |  | White                                                                        |                              | 10-1-1903                                                                       |  |                                                                                                                                                          | 65 YRS.                         |                                                                                         | MONTHS DAYS HOURS MIN |                                                                                        |                                              |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                             |  |                                                                              | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |                                                                                         | 9. COUNTY OF DEATH    |                                                                                        |                                              |
| Pennsylvania                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | U.S.A.                       |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         | Baltimore, Md.        |                                                                                        |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                             |  |                                                                              |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |  |                                                                                                                                                          |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                       |                                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                              | St. Joseph Hospital                                                             |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        | Steel                                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                         |  |                                                                              |                              |                                                                                 |  | 13c. CITY OR TOWN                                                                                                                                        |                                 | 13d. INSIDE CITY LIMITS?                                                                |                       | 13e. STREET AND NUMBER                                                                 |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                              |                                                                                 |  | Baltimore                                                                                                                                                |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                       | 4710 Simms Ave.                                                                        |                                              |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                              |                                                                                 |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                                                                                               |                                 |                                                                                         |                       |                                                                                        |                                              |
| Joseph J. Ruzakowski                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              |                              |                                                                                 |  | Bernice Wolkiewicz                                                                                                                                       |                                 |                                                                                         |                       |                                                                                        |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)                                                                                                                                                                                                                                                                                    |  |                                                                              |                              | 16b. SOCIAL SECURITY NO.                                                        |  | 17. INFORMANT Address                                                                                                                                    |                                 |                                                                                         |                       |                                                                                        |                                              |
| Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                              |                                                                                 |  | Mrs. Laura Ruzakowski 4710 Simms Ave.                                                                                                                    |                                 |                                                                                         |                       |                                                                                        |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                             |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain tumors, multiple, metastatic</u><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the left lung</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)                                                    |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                    |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
| Arteriosclerotic cardiovascular disease                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                              |                                                                                 |  | 20a. AUTOPSY?                                                                                                                                            |                                 | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |                       |                                                                                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                              |                                                                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |                                 |                                                                                         |                       |                                                                                        |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year                                 |                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
|                                                                                                                                                                                                                                                                                                                                                                       |  | P.M. 19                                                                      |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> ot work <input type="checkbox"/>                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                              |                                                                                 |  | 21f. LOCATION Street or R.F.D. No.                                                                                                                       |                                 | City or Town                                                                            |                       | County State                                                                           |                                              |
|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>1/12/</u> , 19 <u>69</u> , to <u>2/11/</u> , 19 <u>69</u> , that (X) (we) lost saw the deceased alive on <u>2/11/</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       |                                                                                        |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                              |                                                                                 |  | DEGREE                                                                                                                                                   |                                 | ATTENDING PHYS.                                                                         |                       | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                              |
| <div>Arturo A. Pidlaon M.D.</div>                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                              |                                                                                 |  |                                                                                                                                                          |                                 |                                                                                         |                       | 22c. DATE SIGNED                                                                       |                                              |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                              |                                                                                 |  | 22e. ADDRESS                                                                                                                                             |                                 | 22f. ADDRESS                                                                            |                       |                                                                                        |                                              |
| Arturo A. Pidlaon, M.D.                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                              |                                                                                 |  | 7620 York Rd., Towson, Md.                                                                                                                               |                                 | 21204                                                                                   |                       |                                                                                        |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                    |                              | 23c. NAME OF CEMETERY OR CREMATORY                                              |  |                                                                                                                                                          |                                 | 23d. LOCATION (City or Town) (County) (State)                                           |                       |                                                                                        |                                              |
| Burial                                                                                                                                                                                                                                                                                                                                                                |  | 2/14/69                                                                      |                              | Holy Rosary Cemetery                                                            |  |                                                                                                                                                          |                                 | Dundalk, Md.                                                                            |                       |                                                                                        |                                              |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                              |                                                                                 |  | 25a. REC'D BY REGISTRAR DATE                                                                                                                             |                                 | 25b. REGISTRAR'S SIGNATURE                                                              |                       |                                                                                        |                                              |
| Ulrich Funeral Home 4210 Belair Road.                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                              |                                                                                 |  | FEB 14 1969                                                                                                                                              |                                 | <div> <div>1</div> <div>02108</div> </div>                                              |                       |                                                                                        |                                              |

80180

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                              |                                                                                                                                                          |                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Item 16b 02113                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                              |                                                                                   |
| Items 1&4 Film 409 2/13/69 kk                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              | CERTIFICATE OF DEATH                                                                                                                                     |                                                                                   |
| 1. DECEASED-NAME (Type or print) <u>Lena R. St. John</u>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              | 2a. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>69</u>                                                                                             |                                                                                   |
| 3. SEX <u>FEMALE</u>                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE <u>WHITE</u>                                                                                         | 5. DATE OF BIRTH <u>11-14-02</u>                                                                                                                         | 2b. HOUR <u>1:30 AM</u>                                                           |
| 7a. BIRTHPLACE (State or foreign country) <u>LOUISIANA</u>                                                                                                                                                                                                                                                                                                                                                      | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <u>BALTIMORE</u> Md.                                           |
| 10. CITY OR TOWN OF DEATH <u>RANDALLSTOWN</u>                                                                                                                                                                                                                                                                                                                                                                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>BALTIMORE CO. GEN. HOSP.</u> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>President - (retired)</u>                                     | 12b. KIND OF BUSINESS OR INDUSTRY <u>MARCO, Co</u>                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>                                                                                                                                                                                                                                                                                                   | 13b. COUNTY <u>BALTIMORE</u>                                                                                 | 13c. CITY OR TOWN <u>BALTIMORE</u>                                                                                                                       | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First <u>Nichols</u> Middle <u>a/k/a Nichols</u> Last <u>Cassidy</u>                                                                                                                                                                                                                                                                                                                          | 15. MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>McGRAY</u> Last <u>McGRAY</u>                           | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes, no, or (unknown)</u>                                          |                                                                                   |
| 16b. SOCIAL SECURITY NO. <u>216-10-9929</u>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                              | 17. INFORMANT <u>HOSPITAL RECORDS</u>                                                                                                                    |                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>same</u> |                                                                                                              |                                                                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                              |                                                                                                              |                                                                                                                                                          |                                                                                   |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>                                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                                          |                                                                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                        | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-8</u> , 19 <u>69</u> , to <u>2-9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-9-19-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                            |                                                                                                              |                                                                                                                                                          |                                                                                   |
| 22b. SIGNATURE <u>Angelita A. Topacio</u>                                                                                                                                                                                                                                                                                                                                                                       | DEGREE <u>ANGELITA TOPACIO</u>                                                                               | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          | 22c. DATE SIGNED <u>2-9-69</u>                                                    |
| 22d. PHYSICIAN'S NAME (Type) <u>ANGELITA TOPACIO</u>                                                                                                                                                                                                                                                                                                                                                            | 22e. ADDRESS <u>BL 9th</u>                                                                                   |                                                                                                                                                          |                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                         | 23b. DATE <u>2-12-1969</u>                                                                                   | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>                                                                                                  | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>          |
| 24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson</u>                                                                                                                                                                                                                                                                                                                                                               | ADDRESS <u>1050 York Road Towson, Md 21204</u>                                                               | 25a. REC'D BY REGISTRAR <u>FEB 10 1969</u>                                                                                                               | 25b. REGISTRAR'S SIGNATURE <u>William Judge</u>                                   |

02100

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

Very respectfully,  
J. A. Smith  
10/10/10  
B-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-60

| 02114                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                       |  |  |  |  |  |  |  |  |  | 02110                                                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|---------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                                                                                 |  |  |  |  |  |  |  |  |  | 2b. HOUR                                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Yetta SANDLER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | Month Day Year<br>2 27 69                                                                         |  |  |  |  |  |  |  |  |  | 130 AM                                                                                                                                                      |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>F.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 4. RACE<br>W.                                                                                     |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>July 20, 1907                                                                                                                           |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)<br>61 YRS.                                                   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                   |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                               |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                                          |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>4710 Old Court Rd |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife                                                        |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Baltimore                                                                          |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>4710 Old Court Road |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Felix                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Fannie                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>No                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>—                                                                     |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>Henry Sandler                                                                                                                              |  |  |  |  |  |  |  |  |  | Address<br>Same                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE BREAST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GENERALIZED METASTASES</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>174X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>13 Years                                          |  |  |  |  |  |  |  |  |  |                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                           |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                              |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10-1967, to 2-27-1969, that (I) (we) last saw the deceased alive on 2-27-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                        |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>Cesar Valle Caverio                                                             |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>2-27-69                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>CESAR VALLE CAVERO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>8629 Liberty Rd                                                                   |  |  |  |  |  |  |  |  |  |                                                                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 23b. DATE<br>2/28/1969                                                                            |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Beth Jacob Vesheer                                                                                                    |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Rosedale Maryland                           |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Stephen L. Lewis & Son Inc. 9610 Reisterstown Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 28 1969                                                       |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

27150

1. What is the main purpose of the study?

• • •

... ..



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                          |  | First Middle Last                                                                                                                                        |  | 2a. DATE OF DEATH                                                                             |  | 2b. HOUR                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|--|----------------------------|--|
| CATENA                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                          |  | SCAVONE                                                                                                                                                  |  | February 10, 1969                                                                             |  | 9:25 PM                    |  |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                                                                                                                                                                  |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (In years lost birthday)                                                               |  | IF UNDER 1 YEAR            |  |
| Female                                                                                                                                                                                                                                                                                                       |  | White                                                                                                                                                                                                                    |  | April 7, 1892                                                                                                                                            |  | 76 YRS.                                                                                       |  | MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                                            |  | 10. CITY OR TOWN OF DEATH  |  |
| Italy                                                                                                                                                                                                                                                                                                        |  | U.S.A.                                                                                                                                                                                                                   |  |                                                                                                                                                          |  | Baltimore, Md.                                                                                |  | Towson                     |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                                                                                                                                                                                                                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)                                                                                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                        |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE |  | 13b. COUNTY                |  |
| St. Joseph's Hospital                                                                                                                                                                                                                                                                                        |  | Housewife                                                                                                                                                                                                                |  |                                                                                                                                                          |  | Md.                                                                                           |  | Baltimore                  |  |
| 13c. CITY OR TOWN                                                                                                                                                                                                                                                                                            |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                             |  | 13e. STREET AND NUMBER                                                                                                                                   |  | 13f. CITY OR TOWN                                                                             |  | 13g. COUNTY                |  |
| Baltimore                                                                                                                                                                                                                                                                                                    |  | EX                                                                                                                                                                                                                       |  | 1818 Wildwood Avenue                                                                                                                                     |  | Baltimore                                                                                     |  | Baltimore                  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  | 15. MOTHER'S MAIDEN NAME                                                                                                                                                                                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)                                                   |  | 16b. SOCIAL SECURITY NO.                                                                      |  | 17. INFORMANT              |  |
| Michael                                                                                                                                                                                                                                                                                                      |  | Maria                                                                                                                                                                                                                    |  | No                                                                                                                                                       |  |                                                                                               |  | Michael Scavone            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                    |  | 19. DATE OF OPERATION                                                                                                                                                                                                    |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                    |  | 21. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                |  | 22. DATE SIGNED            |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Atherosclerosis Cardiovascular (b) Disease - Terminal Myocardial (c) In function                                                                                                                                                                       |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hiatus hernia large in the thoracic; Aortic aneurysm and Thoracic vertebrae collapse |  | 22b. SIGNATURE John C. Hyle MD.                                                                                                                          |  | 22c. ADDRESS 7527 Belair Rd 21236 Baltimore                                                   |  | 22d. DATE SIGNED 2-11-69   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7:00, 1969, to 2:10, 1969, that (I) (we) last saw the deceased alive on 2-10-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE                                                                                                                                                                                                           |  | 22c. ADDRESS                                                                                                                                             |  | 22d. DATE SIGNED                                                                              |  | 22e. SIGNATURE             |  |
| John C. Hyle MD.                                                                                                                                                                                                                                                                                             |  | 7527 Belair Rd 21236 Baltimore                                                                                                                                                                                           |  | 2-11-69                                                                                                                                                  |  | Charles Judge                                                                                 |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                                                                                                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)                                                 |  | 23e. REC'D BY REGISTRAR    |  |
| Buried Entomb 2/13/69                                                                                                                                                                                                                                                                                        |  | 2/13/69                                                                                                                                                                                                                  |  | Lorraine Maus.                                                                                                                                           |  | Baltimore, Maryland                                                                           |  | FEB 11 1969                |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                         |  | 24a. ADDRESS                                                                                                                                                                                                             |  | 24b. REGISTRAR'S SIGNATURE                                                                                                                               |  | 24c. REGISTRAR'S SIGNATURE                                                                    |  | 24d. REGISTRAR'S SIGNATURE |  |
| Leonard J. Ruck, Inc. Balto. Md. 21214                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                          |  | Charles Judge                                                                                                                                            |  |                                                                                               |  |                            |  |

11150 05117 05118 05119 05120 05121 05122 05123 05124 05125 05126 05127 05128 05129 05130 05131 05132 05133 05134 05135 05136 05137 05138 05139 05140 05141 05142 05143 05144 05145 05146 05147 05148 05149 05150 05151 05152 05153 05154 05155 05156 05157 05158 05159 05160 05161 05162 05163 05164 05165 05166 05167 05168 05169 05170 05171 05172 05173 05174 05175 05176 05177 05178 05179 05180 05181 05182 05183 05184 05185 05186 05187 05188 05189 05190 05191 05192 05193 05194 05195 05196 05197 05198 05199 05200

05117 05118 05119 05120 05121 05122 05123 05124 05125 05126 05127 05128 05129 05130 05131 05132 05133 05134 05135 05136 05137 05138 05139 05140 05141 05142 05143 05144 05145 05146 05147 05148 05149 05150 05151 05152 05153 05154 05155 05156 05157 05158 05159 05160 05161 05162 05163 05164 05165 05166 05167 05168 05169 05170 05171 05172 05173 05174 05175 05176 05177 05178 05179 05180 05181 05182 05183 05184 05185 05186 05187 05188 05189 05190 05191 05192 05193 05194 05195 05196 05197 05198 05199 05200

05117 05118 05119 05120 05121 05122 05123 05124 05125 05126 05127 05128 05129 05130 05131 05132 05133 05134 05135 05136 05137 05138 05139 05140 05141 05142 05143 05144 05145 05146 05147 05148 05149 05150 05151 05152 05153 05154 05155 05156 05157 05158 05159 05160 05161 05162 05163 05164 05165 05166 05167 05168 05169 05170 05171 05172 05173 05174 05175 05176 05177 05178 05179 05180 05181 05182 05183 05184 05185 05186 05187 05188 05189 05190 05191 05192 05193 05194 05195 05196 05197 05198 05199 05200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                             |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                     |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                            |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                |  |                                                                             | First Middle Last                                                            |                                                                                                                                                          |                                                                                   | 2a. DATE OF DEATH                                                                                                               |                                                                                   |                                   | 2b. HOUR                                     |
| JOHN                                                                                                                                                                                                                                                                                                            |  |                                                                             | NMN SCHEUFEL                                                                 |                                                                                                                                                          |                                                                                   | 02 <sup>Month</sup> 26 <sup>Day</sup> 69 <sup>Year</sup>                                                                        |                                                                                   |                                   | 4:30 <sup>M</sup>                            |
| 3. SEX                                                                                                                                                                                                                                                                                                          |  | 4. RACE                                                                     |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                   | 6. AGE (In years last birthday)                                                                                                 |                                                                                   | IF UNDER 1 YEAR                   |                                              |
| MALE                                                                                                                                                                                                                                                                                                            |  | CAUC                                                                        |                                                                              | 12-26-91                                                                                                                                                 |                                                                                   | 12-26-91                                                                                                                        |                                                                                   | MONTHS DAYS HOURS MIN             |                                              |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                       |  | 7b. CITIZEN OF WHAT COUNTRY?                                                |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                                                              |                                                                                   |                                   |                                              |
| Balto. Md.                                                                                                                                                                                                                                                                                                      |  | U.S.A.                                                                      |                                                                              |                                                                                                                                                          |                                                                                   | BALTIMORE COUNTY Md.                                                                                                            |                                                                                   |                                   |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |  |                                                                             | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                         |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |
| TOWSON, MD.                                                                                                                                                                                                                                                                                                     |  |                                                                             | GRTR. BALTO. MED. CENTER                                                     |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                   |  |                                                                             | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                                 |                                                                                                                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |
| Md.                                                                                                                                                                                                                                                                                                             |  |                                                                             | -                                                                            |                                                                                                                                                          | Balto                                                                             |                                                                                                                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 4617 Waltham Ave                             |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                               |  |                                                                             | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| First Middle Last                                                                                                                                                                                                                                                                                               |  |                                                                             | First Middle Last                                                            |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| George                                                                                                                                                                                                                                                                                                          |  |                                                                             | Scheufel                                                                     |                                                                                                                                                          |                                                                                   | Mabel                                                                                                                           |                                                                                   |                                   |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)                                                                                                                                                                                                                                              |  |                                                                             | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT                                                                     |                                                                                                                                 | Address                                                                           |                                   |                                              |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                             |                                                                              |                                                                                                                                                          | Josephine M. Scheufel                                                             |                                                                                                                                 | 4617 Waltham Ave                                                                  |                                   |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                       |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                    |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   | IMMEDIATE                                    |
| IMMEDIATE CAUSE (a) 1621 CARDIO-RESPIRATORY FAILURE                                                                                                                                                                                                                                                             |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| DUE TO, OR AS A CONSEQUENCE OF (b) CA OF LUNG                                                                                                                                                                                                                                                                   |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   | 7 MONTHS                                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)                                                                                                                                                                                                              |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                              |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                   |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                              |  | 21b. TIME OF INJURY                                                         |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
|                                                                                                                                                                                                                                                                                                                 |  | HOUR A.M. Month Day Year P.M. 19                                            |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) |                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
|                                                                                                                                                                                                                                                                                                                 |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-25, 1969, to 2-26, 1969, that (I) (we) last saw the deceased alive on 2-26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                  |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   | DEGREE                                                                                                                          |                                                                                   | 22c. DATE SIGNED                  |                                              |
| E. M. Canilang                                                                                                                                                                                                                                                                                                  |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                                                                   | 2-26-69                           |                                              |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                    |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   | 22e. ADDRESS                                                                                                                    |                                                                                   |                                   |                                              |
| E. CANILANG                                                                                                                                                                                                                                                                                                     |  |                                                                             |                                                                              |                                                                                                                                                          |                                                                                   | 6701 NOTH CHARLES STREET                                                                                                        |                                                                                   |                                   |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                       |  | 23b. DATE                                                                   |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                   | 23d. LOCATION (City or Town) (County) (State)                                                                                   |                                                                                   |                                   |                                              |
| Burial                                                                                                                                                                                                                                                                                                          |  | Mar. 1-1969                                                                 |                                                                              | Maidland Mem.                                                                                                                                            |                                                                                   | Balto Md.                                                                                                                       |                                                                                   |                                   |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                            |  |                                                                             |                                                                              | ADDRESS                                                                                                                                                  |                                                                                   | 25a. REC'D BY REGISTRAR                                                                                                         |                                                                                   | 25b. REGISTRAR'S SIGNATURE        |                                              |
| Thelma Hoffmann                                                                                                                                                                                                                                                                                                 |  |                                                                             |                                                                              | 3218 Hudson St.                                                                                                                                          |                                                                                   | MAR 3 1969                                                                                                                      |                                                                                   | Thelma Hoffmann                   |                                              |

05115

05115

TO: [illegible] FROM: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

02117

## CERTIFICATE OF DEATH

02113

|                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Carl</b> <b>M</b> <b>Schneider Sr</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                    | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>12</b> Year <b>69</b> |                                                                                                                                                             |  | 2b. HOUR <b>1:15</b> <b>A</b> <b>M</b>                                               |                                                                                               |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>White</b>                                                                                            |                                                                  | 5. DATE OF BIRTH<br><b>Nov, 18, 1895</b>                                                                                                                    |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.                                    |                                                                                               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                      |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                           |                                                                                               |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Dulaney Valley Nursing Home</b> |                                                                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Salesman</b>                                          |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |                                                                                               |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Balto.</b>                                                                                       |                                                                  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                               |
| 13e. STREET AND NUMBER<br><b>22 Murdock Rd</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 14. FATHER'S NAME First Middle Last<br><b>Max Joseph Schneider</b>                                                 |                                                                  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Anna Arnold</b>                                                                                            |  |                                                                                      |                                                                                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-3824</b>                                                                     |                                                                  | 17. INFORMANT<br><b>Mr Carl M Schneider</b>                                                                                                                 |  | Address<br><b>Same</b>                                                               |                                                                                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>2509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral &amp; General Arterio Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b> |  |                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Days</b><br><b>5 Yrs</b><br><b>5 Yrs</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                    |  |                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |                                                                                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                   |                                                                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |                                                                                               |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                  |                                                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                      |                                                                                               |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |                                                                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                      |                                                                                               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>Feb 12</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb 11</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                               |  |                                                                                                                    |                                                                  |                                                                                                                                                             |  |                                                                                      |                                                                                               |
| 22b. SIGNATURE<br><i>Walter T. Kees</i>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                    |                                                                  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>Feb 12, 1969</b>                                              |                                                                                               |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Walter Kees</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                    |                                                                  | 22e. ADDRESS<br><b>Cockeysville, Maryland</b>                                                                                                               |  |                                                                                      |                                                                                               |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>2/15/69</b>                                                                                        |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>          |                                                                                               |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                    |                                                                  | ADDRESS                                                                                                                                                     |  | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1969</b>                                        |                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                    |                                                                  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                                                                                          |  |                                                                                      |                                                                                               |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02117

02113

1951 12 22 10:11 AM

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

Washington, D. C.

Dear Sir:

Reference is made to your letter of December 17, 1951.

Enclosed for you are two copies of a letterhead memorandum.

Very truly yours,

John Edgar Hoover

Director

Enclosure

Very truly yours,

John Edgar Hoover

Director

Enclosure

Very truly yours,

John Edgar Hoover

Director

Enclosure



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MIDDLE                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | LAST                                                                                                                                   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                                                                                                                                        |  |  |  |  |  |  |  |  |  | 2b. HOUR                                                                                     |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|----------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) P ETER                                                                                                                                                                                                                                                                     |  |  |  |  |  |  |  |  |  | L. M. SCHOLLECK                                                                                                                        |  |  |  |  |  |  |  |  |  | FEBRUARY 2, 1969                                                                                                                                         |  |  |  |  |  |  |  |  |  | 7:45 AM                                                                                      |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX MALE                                                                                                                                                                                                                                                                                                 |  |  |  |  |  |  |  |  |  | 4. RACE WHITE                                                                                                                          |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH JUNE 17, 1923                                                                                                                           |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) 45 YRS.                                                      |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                                       |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) GERMANY                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                                                    |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH BALTIMORE                                                                 |  |  |  |  |  |  |  |  |  | Md.                                                               |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH BALTIMORE                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6811 CHEROKEE DRIVE                                       |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) EXAMINER                                                         |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY TITLE                                                      |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND                                                                                                                                                                                                      |  |  |  |  |  |  |  |  |  | 13b. COUNTY BALTIMORE                                                                                                                  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN                                                                                                                                        |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER 6811 CHEROKEE DRIVE                        |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last LEO SCHOLLECK                                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | 15. MOTHER'S, MAIDEN NAME First Middle Last IRMA ?                                                                                     |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES                                                                                     |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. W.W. 11 ARMY                                                        |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address MRS. CHARLOTTE SCHOLLECK, 6811 CHEROKEE DR. |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma bronchus                                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  | 8 months                                                                                                                                                 |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 1621 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                              |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF                                                                                                                       |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| (c)                                                                                                                                                                                                                                                                                                         |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none                                                                                                                                                                    |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION June 9 1968                                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Propag pulmonary mass                                                                 |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                                                                   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                    |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                           |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1947, to Feb 2, 1969, that (I) (we) last saw the deceased alive on Jan 29 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                                                                                                                        |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Herbert Gundersheimer M.D.                                                                                                                                                                                                                                                                   |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 2-2-69                                                                                                                                  |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) HERBERT GUNDERSHEIMER                                                                                                                                                                                                                                                          |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 901 Lake Drive                                                                                                            |  |  |  |  |  |  |  |  |  |                                                                                                                                                          |  |  |  |  |  |  |  |  |  |                                                                                              |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL                                                                                                                                                                                                                                                            |  |  |  |  |  |  |  |  |  | 23b. DATE 2-4-69                                                                                                                       |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY OHEB SMALOM MEMORIAL PARK                                                                                             |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) REISTERSTOWN, MARYLAND                         |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                           |  |  |  |  |  |  |  |  |  | ADDRESS                                                                                                                                |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE FEB 6 1969                                                                                                                  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |  |  |  |  |  |  |  |  |                                                                   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

05114

OFFICE OF THE

05114

RECEIVED FEBRUARY 1, 1962 1:42 P.M.

ALL WHITE TIME 11:10 AM

GERMANY U.S.A. BALTIMORE

BALTIMORE 8311 CHEROKEE DRIVE EXAMINER TITLE

MARYLAND BALTIMORE X 8311 CHEROKEE DRIVE

LEO SCHWILCK THRU

W2 D.O. TO ARMY 102. CANTALIE SCHWILCK, 8311 CHEROKEE DR.

ORIGINAL -4-62 ONE SHAW MEMORIAL PARK FEISTERS, MARYLAND

201 LEVINSON & BROS., 3010 FEISTERS-ROAD

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

02119

02115

|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Jean McFarland Schultheis</b>                                                                                                                                                                                                                                                                                                                                                             |                                                 |                                                                                                                                                             | 2a. DATE OF DEATH<br>2 Month <b>9</b> Day <b>69</b> Year |                                                                                                            | 2b. HOUR<br>M                                                   |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE<br><b>White</b>                         | 5. DATE OF BIRTH<br><b>10/4/25</b>                                                                                                                          |                                                          | 6. AGE (In years lost birthday)<br><b>43</b> YRS.                                                          | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore Md.</b>                                                                                                                                                                                                                                                                                                                                                                                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore County Md.</b>        |                                                                                                            |                                                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Balto. Co. Gen. Hosp.</b>                                                |                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Personal</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Arch't Co.</b>          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                           |                                                 | 13b. COUNTY<br><b>Balto.</b>                                                                                                                                | 13c. CITY OR TOWN<br><b>Pikesville</b>                   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               | 13e. STREET AND NUMBER<br><b>722 Leafydale Terrace</b>          |
| 14. FATHER'S NAME First Middle Last<br><b>William McFarlane</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                 | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Clara A. Levey</b>                                                                                         |                                                          |                                                                                                            |                                                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service) <b>none</b>                                                                                                                                                                                                                                                                                                                          |                                                 | 16b. SOCIAL SECURITY NO.<br><b>220-18-8179</b>                                                                                                              |                                                          | 17. INFORMANT Address<br><b>B. Seibert, Balto. Co Gen Hosp</b>                                             |                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6-8 hrs.</b> |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                    |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |                                                                 |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                  |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                    |                                                 | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                                                           |                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                            |                                                                 |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                        |                                                 | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                               |                                                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1935</b> , 19____, to <b>9 Feb 1969</b> , that (I) (we) lost saw the deceased alive on <b>9 Feb 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                             |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
| 22b. SIGNATURE<br><b>Lamirston L. Neown M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                 | 22c. DATE SIGNED<br><b>9 Feb 1969</b>                                                                                                                       |                                                          | 22d. PHYSICIAN'S NAME (Type)<br><b>LAMIRSTON L. NEOWN M.D.</b>                                             |                                                                 |
| 22e. ADDRESS<br><b>431 EAST ALICE AVE BALTIMORE, MD 21212</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                             |                                                 | 23b. DATE<br><b>Feb. 12, 1969</b>                                                                                                                           |                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wm. H. Hodge Cemetery</b>                                         |                                                                 |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Balto Md.</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                 |                                                                                                                                                             |                                                          |                                                                                                            |                                                                 |
| 24. FUNERAL DIRECTOR<br><b>Frank A. Howell, Pikesville, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                 | 25a. REC'D BY REGISTRAR<br><b>DATE FEB 17 1969</b>                                                                                                          |                                                          | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                                         |                                                                 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02112

02112

Grant Humphreys

188

904 62

1932

62

904

X

W. H. H.

W. H. H.

W. H. H.

904 62

W. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MD. STATE DEPT. OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02120

02116

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                                                                 |                                          |                                                             |       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------|-------|
| 1. DECEASED-NAME<br>(Type or print)<br><b>CLIFFORD GUSTAVE SCHWOCH</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>14</b> Year <b>1969</b>                                               |                                                                                                                                                             |                                                                                      | 2b. HOUR<br><b>11:30</b>                                                                                   |                                                                                                 |                                          |                                                             |       |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>CAUCASIAN</b>                                                  |                                                                                                                         | 5. DATE OF BIRTH<br><b>AUGUST 14, 1906</b>                                                                                                                  |                                                                                      | 6. AGE (In years lost birthday)<br><b>62</b> YRS.                                                          |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                                                             |       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MINNESOTA</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |                                                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                     |                                                                                                 |                                          |                                                             |       |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOSPITAL VETERANS ADMINISTRATION</b> |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SALESMAN</b> |                                                                                                 |                                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PETROLEUM</b>       |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              | 13b. COUNTY<br><b>BALTIMORE</b>                                                                                         |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                                |                                                                                                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                          | 13e. STREET AND NUMBER<br><b>12 DOVETAIL LANE</b>           |       |
| 14. FATHER'S NAME First Middle Last<br><b>GUSTAVE SCHWOCH</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                                         | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>GERTRUDE ABBOTT</b>                                                                                        |                                                                                      |                                                                                                            |                                                                                                 |                                          |                                                             |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)<br><b>WW II</b>                                                                                                                                                                                                                                                                                            |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>263 18 3842</b>                                                                          |                                                                                                                                                             | 17. INFORMANT Address<br><b>CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD</b>         |                                                                                                            |                                                                                                 |                                          |                                                             |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b><br><b>4290</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CEREBRAL ARTERIOSCLEROTIC CARDIOVASCULAR ACCIDENT</b> Months<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HYPERTROPHY OF HEART</b>                     |  |                                                                              |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                                                                 |                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Days</b> |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                                                                 |                                          |                                                             |       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                         |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                                            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                          |                                                             |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                      |                                                                                                            |                                                                                                 |                                          |                                                             |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                 |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                                                                                                         | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                                      | City or Town                                                                                               |                                                                                                 | County                                   |                                                             | State |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/25/68</b> , 19__, to <b>2/14/69</b> , 19__, that <input checked="" type="checkbox"/> (we) lost the deceased on <b>2/14/69</b> , 19__, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>XXXX</del> view the body after death. |  |                                                                              |                                                                                                                         |                                                                                                                                                             |                                                                                      |                                                                                                            |                                                                                                 |                                          |                                                             |       |
| 22b. SIGNATURE<br><i>Pushpendra Senan</i>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                                                                                                                         | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |                                                                                      | 22c. DATE SIGNED<br><b>2 15 69</b>                                                                         |                                                                                                 |                                          |                                                             |       |
| 22d. PHYSICIAN'S NAME (Type)<br><b>PUSHPENDRA SENAN, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                                         | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>                                                                                                   |                                                                                      |                                                                                                            |                                                                                                 |                                          |                                                             |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 23b. DATE<br><b>2/18/69</b>                                                  |                                                                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                                                                                             |                                                                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                                |                                                                                                 |                                          |                                                             |       |
| 24. FUNERAL DIRECTOR<br><b>CONNELLY FUNERAL HOME</b><br>300 Mace Avenue<br>Baltimore, 21, Md.                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                                         | 25. REC'D BY REGISTRAR<br><b>FEB 19 1969</b><br>DATE                                                                                                        |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                           |                                                                                                 |                                          |                                                             |       |

03113

U.S. DEPARTMENT OF JUSTICE

1957

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div>02121</div> <div> <div>02117</div> <div> <div>1</div> <div> <div>FOR STATE HEALTH DEPT.</div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> </div> </div> </div> |         |                              |                                                                                                                                    |                                                                                       |                  |                                                                                                                                                                                                      |  |  |                                                                    |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME (Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              | First Middle Last                                                                                                                  |                                                                                       |                  | 2a. DATE KNOWN OF DEATH                                                                                                                                                                              |  |  | 2b. HOUR                                                           |  |  |
| FRANK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |                              | A. SEALOVER, JR.                                                                                                                   |                                                                                       |                  | <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year<br><input type="checkbox"/> Feb. 26, 1969                                                       |  |  | <input type="checkbox"/> M<br><input type="checkbox"/> 1969        |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)                                                                                                    | IF UNDER 1 YEAR                                                                       | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                                                                                                                                                                             |  |  | 2d. HOUR                                                           |  |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | White   | Nov. 29, 1929                | 59 YRS.                                                                                                                            | MONTHS                                                                                | DAYS             | Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/><br>2-26-1969                                                                                               |  |  | <input type="checkbox"/> M<br><input type="checkbox"/> 1969        |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | 7b. CITIZEN OF WHAT COUNTRY? |                                                                                                                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH                                                                                                                                                                                   |  |  | Md.                                                                |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         | U.S.A.                       |                                                                                                                                    | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |                  | Baltimore                                                                                                                                                                                            |  |  |                                                                    |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                                       |                                                                                       |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                                                              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |  |
| Dundalk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                              | 7615 Cypress Ave                                                                                                                   |                                                                                       |                  | Truck driver                                                                                                                                                                                         |  |  |                                                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              | 13b. COUNTY                                                                                                                        |                                                                                       |                  | 13c. CITY OR TOWN                                                                                                                                                                                    |  |  | 13d. INSIDE CITY LIMITS?                                           |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                              | Carroll                                                                                                                            |                                                                                       |                  | Finksburg                                                                                                                                                                                            |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/><br>Box 41 |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                              | 15. MOTHER'S MAIDEN NAME                                                                                                           |                                                                                       |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                                                                                                                                         |  |  | 16b. SOCIAL SECURITY NO.                                           |  |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                              | First Middle Last                                                                                                                  |                                                                                       |                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)                                                                                            |  |  |                                                                    |  |  |
| Frank A. Sealover, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                              | Catherine Stitely                                                                                                                  |                                                                                       |                  |                                                                                                                                                                                                      |  |  |                                                                    |  |  |
| 17. INFORMANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |                              | ADDRESS                                                                                                                            |                                                                                       |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                            |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |  |
| Mrs. Yvonne Sealover, Box 41, Finksburg, Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |                              |                                                                                                                                    |                                                                                       |                  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renchogenic Ca of Lys Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)            |  |  |                                                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |                              |                                                                                                                                    |                                                                                       |                  |                                                                                                                                                                                                      |  |  |                                                                    |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                  |                                                                                       |                  | 20. AUTOPSY?                                                                                                                                                                                         |  |  |                                                                    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                              |                                                                                                                                    |                                                                                       |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                  |  |  |                                                                    |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                              | 21b. TIME OF INJURY Month, Day, Year                                                                                               |                                                                                       |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                      |  |  |                                                                    |  |  |
| CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              | HOUR A.M. P.M.                                                                                                                     |                                                                                       |                  |                                                                                                                                                                                                      |  |  |                                                                    |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                                       |                                                                                       |                  | 21f. LOCATION Street or R.F.D. No.                                                                                                                                                                   |  |  | City or Town County State                                          |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |                              |                                                                                                                                    |                                                                                       |                  |                                                                                                                                                                                                      |  |  |                                                                    |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                                                                                       |                  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |                                                                    |  |  |
| ACTUAL SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |                              | CHIEF MEDICAL EXAMINER                                                                                                             |                                                                                       |                  | ASSISTANT MEDICAL EXAMINER                                                                                                                                                                           |  |  | 22b. DATE SIGNED                                                   |  |  |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                              | M.B. Davis, M.D. - 6800 Monrovia                                                                                                   |                                                                                       |                  | DEPUTY MEDICAL EXAMINER                                                                                                                                                                              |  |  | 2/27/68                                                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |                              | 23b. DATE                                                                                                                          |                                                                                       |                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                                                                   |  |  | 23d. LOCATION (City or Town) (County) (State)                      |  |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |                              | 3/1/69                                                                                                                             |                                                                                       |                  | Lakeview Memorial Park                                                                                                                                                                               |  |  | Sykesville, Md.                                                    |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |                              | ADDRESS                                                                                                                            |                                                                                       |                  | 25a. REC'D BY REGISTRAR                                                                                                                                                                              |  |  | 25b. REGISTRAR'S SIGNATURE                                         |  |  |
| Luther Haight,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                              | Sykesville, Md.                                                                                                                    |                                                                                       |                  | MAR 3 1969                                                                                                                                                                                           |  |  | Charles Judge                                                      |  |  |



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151-141  
30M. REV. 1-68

| 02122                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |        | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                          |                          |                                                                                                                                        |                                 | 02118                                                                |                                   |                                                       |                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------|------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                  |  |                                                                              |        | First                                                                                                                                                       | Middle                   | Last                                                                                                                                   | 2a. DATE OF DEATH               |                                                                      |                                   | 2b. HOUR                                              |                  |
| Esther                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |        | Leo                                                                                                                                                         | Na                       | Shaw                                                                                                                                   | Month                           | Day                                                                  | Year                              | 2:30 PM                                               |                  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                      |        | 5. DATE OF BIRTH                                                                                                                                            |                          |                                                                                                                                        | 6. AGE (In years lost birthday) |                                                                      | IF UNDER 1 YEAR                   |                                                       | IF UNDER 24 HRS. |
| Female                                                                                                                                                                                                                                                                                                                                                               |  | white                                                                        |        | 4-23-25                                                                                                                                                     |                          |                                                                                                                                        | 43 YRS.                         |                                                                      | MONTHS                            | DAYS                                                  | HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                          | 9. COUNTY OF DEATH                                                                                                                     |                                 |                                                                      |                                   |                                                       |                  |
| Cumberland, Md.                                                                                                                                                                                                                                                                                                                                                      |  | U.S.A.                                                                       |        |                                                                                                                                                             |                          | Baltimore County, Md.                                                                                                                  |                                 |                                                                      |                                   |                                                       |                  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |                                                                                                                                                             |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                |                                 |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY |                                                       |                  |
| Mount Wilson                                                                                                                                                                                                                                                                                                                                                         |  | Mt. Wilson St. Hosp.                                                         |        |                                                                                                                                                             |                          | Housewife                                                                                                                              |                                 |                                                                      |                                   |                                                       |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                        |  | 13b. COUNTY                                                                  |        | 13c. CITY OR TOWN                                                                                                                                           |                          | 13d. INSIDE CITY LIMITS?                                                                                                               |                                 | 13e. STREET AND NUMBER                                               |                                   |                                                       |                  |
| Md.                                                                                                                                                                                                                                                                                                                                                                  |  | Baltia                                                                       |        | Baltimore                                                                                                                                                   |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                    |                                 | 1314 Lemmon St.                                                      |                                   |                                                       |                  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                    |  | First                                                                        | Middle | Last                                                                                                                                                        | 15. MOTHER'S MAIDEN NAME |                                                                                                                                        | First                           | Middle                                                               | Last                              |                                                       |                  |
| Melzie                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |        | Almond                                                                                                                                                      | UNKNOWN                  |                                                                                                                                        |                                 |                                                                      |                                   |                                                       |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.                                                     |        | 17. INFORMANT                                                                                                                                               |                          | Address                                                                                                                                |                                 |                                                                      |                                   |                                                       |                  |
| no                                                                                                                                                                                                                                                                                                                                                                   |  | none                                                                         |        | unknown                                                                                                                                                     |                          | Records, Mt. Wilson State Hospital                                                                                                     |                                 |                                                                      |                                   |                                                       |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Far Advanced pulmonary Tuberculosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                                                                              |        |                                                                                                                                                             |                          |                                                                                                                                        |                                 |                                                                      |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 mo. |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                  |  |                                                                              |        |                                                                                                                                                             |                          |                                                                                                                                        |                                 |                                                                      |                                   |                                                       |                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |                                                                                                                                                             |                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |                                                       |                  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                             |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                          |                                                                                                                                        |                                 |                                                                      |                                   |                                                       |                  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                          |                                                                                                                                        |                                 |                                                                      |                                   |                                                       |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-30</u> , 19 <u>69</u> , to <u>2-13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                                                                              |        |                                                                                                                                                             |                          |                                                                                                                                        |                                 |                                                                      |                                   |                                                       |                  |
| 22b. SIGNATURE<br><u>W. Newcomer</u>                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |        |                                                                                                                                                             |                          | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                 | 22c. DATE SIGNED<br><u>2-13-69</u>                                   |                                   |                                                       |                  |
| 22d. PHYSICIAN'S NAME (Type)<br>William Newcomer, M.D.                                                                                                                                                                                                                                                                                                               |  |                                                                              |        |                                                                                                                                                             |                          | 22e. ADDRESS<br>Mount Wilson, Maryland                                                                                                 |                                 |                                                                      |                                   |                                                       |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                    |        | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                          | 23d. LOCATION (City or Town) (County) (State)                                                                                          |                                 |                                                                      |                                   |                                                       |                  |
| Burial                                                                                                                                                                                                                                                                                                                                                               |  | Feb. 17, 1969                                                                |        | David Ridge Cemetery                                                                                                                                        |                          | Pikesville, Baltia, Md.                                                                                                                |                                 |                                                                      |                                   |                                                       |                  |
| 24. FUNERAL DIRECTOR<br><u>Newell Funeral Home Pikesville Md.</u>                                                                                                                                                                                                                                                                                                    |  |                                                                              |        |                                                                                                                                                             |                          | 25a. REC'D BY REGISTRAR<br>DATE<br><u>FEB 19 1969</u>                                                                                  |                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |                                   |                                                       |                  |

02118

02123

Baltimore County

Mount Wilson

Records, Mt. Wilson State Hospital

Mount Wilson, Maryland

William Rawson, M.D.

10/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1969

| 02123                                                                                                                                                                                                                                                                                                                   |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |                        |  |  |                  |  |  |  |  | 03630    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--|------------------------|--|--|------------------|--|--|--|--|----------|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                        |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              | 2a. DATE OF DEATH                                                           |  |                        |  |  |                  |  |  |  |  | 2b. HOUR |  |
| LAURA REBECCA SHEPPARD                                                                                                                                                                                                                                                                                                  |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              | FEB. 11 1969                                                                |  |                        |  |  |                  |  |  |  |  | 9 P.M.   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                  |  |  | 4. RACE                                                                      |  |  | 5. DATE OF BIRTH                                                                                                                                         |  |  | 6. AGE (In years last birthday)                                                              |                                                                             |  | IF UNDER 1 YEAR        |  |  | IF UNDER 24 HRS. |  |  |  |  |          |  |
| FEMALE                                                                                                                                                                                                                                                                                                                  |  |  | WHITE                                                                        |  |  | 1-28-1885                                                                                                                                                |  |  | 84                                                                                           |                                                                             |  | MONTHS                 |  |  | DAYS             |  |  |  |  |          |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                               |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH                                                                           |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| MD.                                                                                                                                                                                                                                                                                                                     |  |  | U.S.                                                                         |  |  |                                                                                                                                                          |  |  | BALTO.                                                                                       |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                               |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| BALTIMORE                                                                                                                                                                                                                                                                                                               |  |  | SPRING GROVE                                                                 |  |  | H.W.                                                                                                                                                     |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                           |  |  | 13b. COUNTY                                                                  |  |  | 13c. CITY OR TOWN                                                                                                                                        |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                             |  | 13e. STREET AND NUMBER |  |  |                  |  |  |  |  |          |  |
| MD.                                                                                                                                                                                                                                                                                                                     |  |  | BALTO.                                                                       |  |  | TAYMON                                                                                                                                                   |  |  |                                                                                              |                                                                             |  | none                   |  |  |                  |  |  |  |  |          |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                       |  |  | 15. MOTHER'S MAIDEN NAME                                                     |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| LOUIS ENSOR                                                                                                                                                                                                                                                                                                             |  |  | MARY HUTINSON                                                                |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                        |  |  | 16b. SOCIAL SECURITY NO.                                                     |  |  | 17. INFORMANT                                                                                                                                            |  |  | STATE                                                                                        |                                                                             |  | Address                |  |  |                  |  |  |  |  |          |  |
|                                                                                                                                                                                                                                                                                                                         |  |  | 29-54-3422                                                                   |  |  | SPRING GROVE HOSP.                                                                                                                                       |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                                                |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |                        |  |  |                  |  |  |  |  |          |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                                                                                                                                                                                                                                                                        |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 4123 Deteriorated heart disease                                                                                                                                                                                                                                                                                         |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                          |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| (b) with heart failure.                                                                                                                                                                                                                                                                                                 |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                          |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| (c) Pulmonary tuberculosis & old                                                                                                                                                                                                                                                                                        |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                     |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| (b) Schizophrenia, undifferentiated type                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
|                                                                                                                                                                                                                                                                                                                         |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                      |  |  | 21b. TIME OF INJURY                                                          |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
|                                                                                                                                                                                                                                                                                                                         |  |  | HOUR A.M. Month Day Year                                                     |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION                                                                                                                                            |  |  | Street or R.F.D. No.                                                                         |                                                                             |  | City or Town           |  |  | County           |  |  |  |  |          |  |
|                                                                                                                                                                                                                                                                                                                         |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 27, 1969, to Feb. 11, 1969, that (I) (we) last saw the deceased alive on Feb. 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                          |  |  | DEGREE                                                                       |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  | 22c. DATE SIGNED                                                                             |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| RAPHAEL H. MORIN                                                                                                                                                                                                                                                                                                        |  |  |                                                                              |  |  |                                                                                                                                                          |  |  | 5/11/69                                                                                      |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                            |  |  | 22e. ADDRESS                                                                 |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| RAPHAEL H. MORIN                                                                                                                                                                                                                                                                                                        |  |  | SPRING GROVE STATE HOSP.                                                     |  |  |                                                                                                                                                          |  |  |                                                                                              |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                               |  |  | 23b. DATE                                                                    |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |  | 23d. LOCATION (City or Town)                                                                 |                                                                             |  | (County)               |  |  | (State)          |  |  |  |  |          |  |
| BURIAL                                                                                                                                                                                                                                                                                                                  |  |  | 3/15/69                                                                      |  |  | JESSEPS CEMETERY                                                                                                                                         |  |  | COCKEYSVILLE                                                                                 |                                                                             |  |                        |  |  | M.D.             |  |  |  |  |          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                    |  |  | ADDRESS                                                                      |  |  | 25a. REC'D BY REGISTRAR                                                                                                                                  |  |  | 25b. REGISTRAR'S SIGNATURE                                                                   |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |
| John Burns Sons                                                                                                                                                                                                                                                                                                         |  |  | Towson Md.                                                                   |  |  | MAR 17 1969                                                                                                                                              |  |  | Thomas Judge                                                                                 |                                                                             |  |                        |  |  |                  |  |  |  |  |          |  |

MEDICAL CERTIFICATION



2538



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: RHODES FUNERAL HOME BROADWAY, VIRGINIA

MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                      |         |                                                                                                                    |                                    |                                                                                                                                                          |                                                                                              |                        |                                                                      |                             |          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------|-----------------------------|----------|
| 02124                                                                                                                                                                                                                                                                                                                                                                                |         | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |                                    | 02119                                                                                                                                                    |                                                                                              |                        |                                                                      |                             |          |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                                     |         | First                                                                                                              | Middle                             | Last                                                                                                                                                     | 2a. DATE OF DEATH                                                                            | Month                  | Day                                                                  | Year                        | 2b. HOUR |
| ORA                                                                                                                                                                                                                                                                                                                                                                                  |         | DEMPSEY                                                                                                            | SHIPE                              |                                                                                                                                                          | FEBRUARY                                                                                     | 28                     | 1969                                                                 | 4:45AM                      |          |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                               | 4. RACE | 5. DATE OF BIRTH                                                                                                   |                                    |                                                                                                                                                          | 6. AGE (In years lost birthday)                                                              | IF UNDER 1 YEAR MONTHS |                                                                      | IF UNDER 24 HRS. HOURS MIN. |          |
| Male                                                                                                                                                                                                                                                                                                                                                                                 | White   | 1/28/20                                                                                                            |                                    |                                                                                                                                                          | 49                                                                                           |                        |                                                                      |                             |          |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                            |         | 7b. CITIZEN OF WHAT COUNTRY?                                                                                       |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH                                                                           |                        |                                                                      |                             |          |
| West Virginia                                                                                                                                                                                                                                                                                                                                                                        |         | U.S.A.                                                                                                             |                                    | Baltimore, Md.                                                                                                                                           |                                                                                              |                        |                                                                      |                             |          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                            |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                       |                                    |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |                        | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                             |          |
| Fort Howard                                                                                                                                                                                                                                                                                                                                                                          |         | Veterans Administration Hospital                                                                                   |                                    |                                                                                                                                                          | Laborer                                                                                      |                        | Saw Mill                                                             |                             |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                        |         | 13b. COUNTY                                                                                                        |                                    | 13c. CITY OR TOWN                                                                                                                                        | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |                                                                      |                             |          |
| Maryland                                                                                                                                                                                                                                                                                                                                                                             |         | Howard                                                                                                             |                                    | Ellicott City                                                                                                                                            |                                                                                              | Woodland Road          |                                                                      |                             |          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                    |         | First                                                                                                              | Middle                             | Last                                                                                                                                                     | 15. MOTHER'S MAIDEN NAME                                                                     |                        | First                                                                | Middle                      | Last     |
| Benjamin                                                                                                                                                                                                                                                                                                                                                                             |         | C.                                                                                                                 | Shipe                              |                                                                                                                                                          | Pearl                                                                                        |                        |                                                                      | Ritchie                     |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                   |         | 16b. SOCIAL SECURITY NO.                                                                                           |                                    | 17. INFORMANT Address                                                                                                                                    |                                                                                              |                        |                                                                      |                             |          |
| Yes                                                                                                                                                                                                                                                                                                                                                                                  |         | WW-11                                                                                                              |                                    | 236 12 81 68 Clinical Rcds VA Hospital, Fort Howard, Md.                                                                                                 |                                                                                              |                        |                                                                      |                             |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u><br><u>571.9</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>LIVER CIRRHOSIS</u><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |         |                                                                                                                    |                                    |                                                                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Weeks</u><br><br><u>Years</u>           |                        |                                                                      |                             |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                   |         |                                                                                                                    |                                    |                                                                                                                                                          |                                                                                              |                        |                                                                      |                             |          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                               |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                   |                                    |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                        | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                   |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                                               |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                              |                        |                                                                      |                             |          |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                             |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |                                    | 21f. LOCATION Street or R.F.D. No.                                                                                                                       |                                                                                              | City or Town           |                                                                      | County                      | State    |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Jan. 15</u> , 19 <u>69</u> , to <u>Feb. 28</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Feb. 28</u> , 19 <u>69</u> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.      |         |                                                                                                                    |                                    |                                                                                                                                                          |                                                                                              |                        |                                                                      |                             |          |
| 22b. SIGNATURE <u>Peter Juvan</u>                                                                                                                                                                                                                                                                                                                                                    |         | DEGREE                                                                                                             |                                    | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          | 22c. DATE SIGNED <u>2/28/69</u>                                                              |                        |                                                                      |                             |          |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                         |         | PETER JUWAN, M.D.                                                                                                  |                                    |                                                                                                                                                          | 22e. ADDRESS <u>VA Hospital, Fort Howard, Maryland</u>                                       |                        |                                                                      |                             |          |
| 23a. BURIAL, CREMATION, REMOVA (Specify)                                                                                                                                                                                                                                                                                                                                             |         | 23b. DATE                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                                                                                          | 23d. LOCATION (City or Town) (County) (State)                                                |                        |                                                                      |                             |          |
| Burial                                                                                                                                                                                                                                                                                                                                                                               |         | 3-5-69                                                                                                             | Family Cem. Cullen                 |                                                                                                                                                          | Broadway, Virginia                                                                           |                        |                                                                      |                             |          |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                 |         | ADDRESS                                                                                                            |                                    | DATE                                                                                                                                                     | 25. REGISTRY REGISTRATION NO.                                                                |                        | 25b. REGISTRAR'S SIGNATURE                                           |                             |          |
| HIGINBOTHOM-SLACK FUNERAL HOME                                                                                                                                                                                                                                                                                                                                                       |         | 106 Columbia Rd.                                                                                                   |                                    | MAR 5 1969                                                                                                                                               | 5 1969                                                                                       |                        | <u>Charles Judge</u>                                                 |                             |          |

21180

10330 30 04-11-1971

02120

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

10330 30 04-11-1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-14  
30M REV 01-68

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 1. DECEASED-NAME<br>(Type or print) <b>RALPH</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                              | First <b>C.</b>                                                                                              |                                                                                 | Middle <b>SIGLER</b>                                                                                                                                        |                                                                                                                  | Last                                                                                            |                                                                        | 2a. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>22</b> Year <b>1969</b> |                           |  |
| 3. SEX<br><b>male</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE<br><b>caucasian</b>                                                  |                                                                                                              |                                                                                 | 5. DATE OF BIRTH<br><b>July 13, 1910</b>                                                                                                                    |                                                                                                                  |                                                                                                 | 6. AGE (In years last birthday)<br><b>58</b> YRS.                      |                                                                       | 2b. HOUR<br><b>3:45AM</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto, Md.</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |                                                                                                              |                                                                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                                                                                                  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |                                                                        |                                                                       |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1618 Glen Keith Blvd.</b> |                                                                                 |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>clerk, retired</b> |                                                                                                 |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O RR</b>                |                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                              | 13b. COUNTY<br><b>Balto.</b>                                                                                 |                                                                                 | 13c. CITY OR TOWN<br><b>Towson</b>                                                                                                                          |                                                                                                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                        | 13e. STREET AND NUMBER<br><b>1618 Glen Keith Blvd.</b>                |                           |  |
| 14. FATHER'S NAME First <b>Roy</b> Middle <b>Cleavland</b> Last <b>Sigler</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |                                                                                                              |                                                                                 | 15. MOTHER'S MAIDEN NAME First <b>Mamie</b> Middle <b>Phillips</b> Last                                                                                     |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>no</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                              |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>705-03-1196</b>                                                               |                                                                                 | 17. INFORMANT Address<br><b>Mrs. Harry E. Harris 1618 Glen Keith Blvd.</b>                                                                                  |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6-15-68</b> |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                              |                                                                                 |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                        |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                                                       |                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                          |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |                                                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-15</b> , 19 <b>68</b> , to <b>2-22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2-20</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             |                                                                                                                  |                                                                                                 |                                                                        |                                                                       |                           |  |
| 22b. SIGNATURE<br><b>Reuben Hoffman, M.D.</b> DEGREE <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. <input type="checkbox"/>                                                                                                                                                                                                                         |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             | 22c. DATE SIGNED<br><b>2-22-69</b>                                                                               |                                                                                                 |                                                                        |                                                                       |                           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Reuben Hoffman</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             | 22e. ADDRESS<br><b>846 W. 36th St, Balto, Md.</b>                                                                |                                                                                                 |                                                                        |                                                                       |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>2/25/69</b>                                                  |                                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>                     |                                                                                                                                                             |                                                                                                                  |                                                                                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Co, Md.</b> |                                                                       |                           |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto, Md. - 14</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                              |                                                                                 |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 24 1969</b>                                                               |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |                                                                       |                           |  |

MEDICAL CERTIFICATION

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M

| <div style="display: flex; justify-content: space-between;"> <span>02126</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02121</span> </div> <div style="text-align: center; font-weight: bold;">             CERTIFICATE OF DEATH           </div>                                                                                                                                                                                           |  |  |                                                                                                              |  |  |                                                                                                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|-----------------------------------------------------------------|--|--|--------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | First<br><b>REINHARD</b>                                                                                     |  |  | Middle<br><b>SIMON</b>                                                                                                                                      |  |  | Last                                                                                         |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>4</b> Year <b>69</b> |  |  | 2b. HOUR<br><b>10:00</b>                         |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 4. RACE<br><b>White</b>                                                                                      |  |  | 5. DATE OF BIRTH<br><b>11-6-98</b>                                                                                                                          |  |  | 6. AGE (In years lost birthday)<br><b>70</b> YRS.                                            |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                |  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                                   |  |  |                                                                 |  |  |                                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Proprietor</b>                                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Baking</b>                                           |  |  |                                                                 |  |  |                                                  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                                                              |  |  | 13c. CITY OR TOWN<br><b>COCKEYSVILLE</b>                                                                                                                    |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>13 Hillary Way, 21030</b>          |  |  |                                                  |  |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Simon</b> Last <b>Simon</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>                   |  |  |                                                                                                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-03-8910-A</b>                                                             |  |  | 17. INFORMANT<br><b>Mrs. Clara Simon</b> Address <b>(Same)</b>                                                                                              |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive infarction of the left cerebral hemisphere</b><br><b>4329</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>thrombosis of left common carotid artery</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |                                                                                                              |  |  |                                                                                                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                              |  |  |                                                                                                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |                                                                 |  |  |                                                  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                            |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                      |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2-2-</b> , 19 <b>69</b> , to <b>2-4</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2-4</b> 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.  |  |  |                                                                                                              |  |  |                                                                                                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 22b. SIGNATURE<br><b>Lawrence F. Misanik, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | DEGREE                                                                                                       |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>2/5/69</b>                                                            |  |  |                                                                 |  |  |                                                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>                                                      |  |  |                                                                                                                                                             |  |  |                                                                                              |  |  |                                                                 |  |  |                                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 23b. DATE<br><b>2/8/69</b>                                                                                   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>                                                                                                     |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                        |  |  |                                                                 |  |  |                                                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | ADDRESS<br><b>4905 York Rd. Balto. 12, Md.</b>                                                               |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 7 1969</b>                                                                                                                |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                             |  |  |                                                                 |  |  |                                                  |  |  |

13130

32100

CONTINUATION OF REPORT

1. SUMMARY

2. INTRODUCTION

3. METHODS

4. RESULTS

5. DISCUSSION

6. CONCLUSIONS

7. REFERENCES

8. APPENDICES

9. FOOTNOTES

10. INDEX

11. GLOSSARY

12. BIBLIOGRAPHY

13. SUMMARY OF THE FACTS OF THE CASE

14. SUMMARY OF THE FACTS OF THE CASE

15. SUMMARY OF THE FACTS OF THE CASE

16. SUMMARY OF THE FACTS OF THE CASE

17. SUMMARY OF THE FACTS OF THE CASE

18. SUMMARY OF THE FACTS OF THE CASE

19. SUMMARY OF THE FACTS OF THE CASE

20. SUMMARY OF THE FACTS OF THE CASE

21. SUMMARY OF THE FACTS OF THE CASE

22. SUMMARY OF THE FACTS OF THE CASE

23. SUMMARY OF THE FACTS OF THE CASE

24. SUMMARY OF THE FACTS OF THE CASE

25. SUMMARY OF THE FACTS OF THE CASE



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |           |                                                                                             |                                                                                                 |  |                                                                                                                                                          |  |                                                                                                 |                                  |                                                |  |                                                                                  |  |            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------|------------------------------------------------|--|----------------------------------------------------------------------------------|--|------------|--|
| 1. DECEASED-NAME<br>(Type or Print) Oscar (none) Singer                                                                                                                                                                                                                                                                                                                                                                                       |  |           | 2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> Month Day Year February 5 1969 |                                                                                                 |  | 2b. HOUR M                                                                                                                                               |  |                                                                                                 |                                  |                                                |  |                                                                                  |  |            |  |
| 3. SEX M                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 4. RACE W |                                                                                             | 5. DATE OF BIRTH 8/28/1894                                                                      |  | 6. AGE (In years last birthday) 74 YRS.                                                                                                                  |  | IF UNDER 1 YEAR MONTHS DAYS                                                                     |                                  | IF UNDER 24 HRS. HOURS MIN                     |  | 2c. DATE PRONOUNCED DEAD February 5 1969                                         |  | 2d. HOUR M |  |
| 7a. BIRTHPLACE (State or foreign country) New York                                                                                                                                                                                                                                                                                                                                                                                            |  |           | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                         |                                                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                                                                 | 9. COUNTY OF DEATH Baltimore Md. |                                                |  |                                                                                  |  |            |  |
| 10. CITY OR TOWN OF DEATH Baltimore                                                                                                                                                                                                                                                                                                                                                                                                           |  |           |                                                                                             | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp. |  |                                                                                                                                                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired |                                  |                                                |  | 12b. KIND OF BUSINESS OR INDUSTRY N.Y. Subway                                    |  |            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland                                                                                                                                                                                                                                                                                                                                        |  |           |                                                                                             | 13b. COUNTY Baltimore                                                                           |  | 13c. CITY OR TOWN Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>               |                                  | 13e. STREET AND NUMBER 2826 Glendale Ave.,     |  |                                                                                  |  |            |  |
| 14. FATHER'S NAME First Middle Last Adam Singer                                                                                                                                                                                                                                                                                                                                                                                               |  |           |                                                                                             | 15. MOTHER'S MAIDEN NAME First Middle Last Josephine Kiebler                                    |  |                                                                                                                                                          |  |                                                                                                 |                                  |                                                |  |                                                                                  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,                                                                                                                                                                                                                                                                                                                                                                        |  |           |                                                                                             | 16b. SOCIAL SECURITY NO. 088-07-5846                                                            |  |                                                                                                                                                          |  | 17. INFORMANT Nellie Singer                                                                     |                                  |                                                |  | ADDRESS Same                                                                     |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Lung<br>(b) Carcinoma of Lung<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1621 2 months + |  |           |                                                                                             |                                                                                                 |  |                                                                                                                                                          |  |                                                                                                 |                                  |                                                |  |                                                                                  |  |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                           |  |           |                                                                                             |                                                                                                 |  |                                                                                                                                                          |  |                                                                                                 |                                  |                                                |  |                                                                                  |  |            |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                        |  |           |                                                                                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                               |  |                                                                                                                                                          |  |                                                                                                 |                                  |                                                |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |            |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                              |  |           |                                                                                             | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19                                          |  |                                                                                                                                                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |                                  |                                                |  |                                                                                  |  |            |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                        |  |           |                                                                                             | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |  |                                                                                                                                                          |  | 21f. LOCATION Street or R.F.D. No.                                                              |                                  | City or Town                                   |  | County                                                                           |  | State      |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                   |  |           |                                                                                             |                                                                                                 |  |                                                                                                                                                          |  |                                                                                                 |                                  |                                                |  |                                                                                  |  |            |  |
| ACTUAL SIGNATURE Chas. F. Orndorff                                                                                                                                                                                                                                                                                                                                                                                                            |  |           |                                                                                             | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                 |  |                                                                                                                                                          |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                             |                                  |                                                |  | 22b. DATE SIGNED 2/5/69                                                          |  |            |  |
| EXAMINER'S NAME (Type) 7501 York Rd. Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                               |  |           |                                                                                             | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |  |                                                                                                                                                          |  | ADDRESS (Street, city, town, or county)                                                         |                                  |                                                |  |                                                                                  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial                                                                                                                                                                                                                                                                                                                                                                                              |  |           |                                                                                             | 23b. DATE 2/10/69                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY Flushing Cemetery                                                                                                     |  |                                                                                                 |                                  | 23d. LOCATION (City or Town) Flushing New York |  | (County)                                                                         |  | (State)    |  |
| 24. FUNERAL DIRECTOR Leonard J Ruck Inc Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                   |  |           |                                                                                             |                                                                                                 |  | 25a. REC'D BY REGISTRAR FEB 7 1969                                                                                                                       |  |                                                                                                 |                                  | 25b. REGISTRAR'S SIGNATURE [Signature]         |  |                                                                                  |  |            |  |

WALLER  
100 111111

00718

00718  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                       |  |                        |  |                      |  |                        |  |                        |  |                      |  |
|-----------------------|--|------------------------|--|----------------------|--|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased      |  | Sex                    |  | Age                  |  | Race                   |  | Date of Death          |  | Place of Death       |  |
| John Doe              |  | Male                   |  | 45                   |  | White                  |  | 10/15/1968             |  | New York             |  |
| Occupation            |  | Cause of Death         |  | Manner of Death      |  | Medical History        |  | Previous Illnesses     |  | Previous Injuries    |  |
| Teacher               |  | Heart Disease          |  | Natural              |  | Hypertension           |  | None                   |  | None                 |  |
| Signature of Examiner |  | Signature of Physician |  | Signature of Coroner |  | Signature of Registrar |  | Signature of Witness   |  | Signature of Family  |  |
| [Signature]           |  | [Signature]            |  | [Signature]          |  | [Signature]            |  | [Signature]            |  | [Signature]          |  |
| Date of Examination   |  | Time of Examination    |  | Place of Examination |  | Signature of Examiner  |  | Signature of Physician |  | Signature of Coroner |  |
| 10/15/1968            |  | 10:00 AM               |  | New York             |  | [Signature]            |  | [Signature]            |  | [Signature]          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|------------------------------------------------------------------------------|------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                        |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                               |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                |  |         | First Middle Last                                                            |                  |  | 2a. DATE OF DEATH                                                                                                                                        |                                 |  | 2b. HOUR                                                                                     |  |                  |                        |  |  |
| Joseph Todd Singleton                                                                                                                                                                                                                                                                                                              |  |         |                                                                              |                  |  | February 27 1969                                                                                                                                         |                                 |  | 12:29                                                                                        |  |                  |                        |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                             |  | 4. RACE |                                                                              | 5. DATE OF BIRTH |  |                                                                                                                                                          | 6. AGE (In years last birthday) |  | 7. UNDER 1 YEAR                                                                              |  | 7. UNDER 24 HRS. |                        |  |  |
| Male                                                                                                                                                                                                                                                                                                                               |  | White   |                                                                              | 2-25-1969        |  |                                                                                                                                                          | YRS.                            |  | MONTHS                                                                                       |  | DAYS             |                        |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                          |  |         | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH                                                                           |  |                  | Md.                    |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                           |  |         | U.S.A.                                                                       |                  |  |                                                                                                                                                          |                                 |  | Baltimore                                                                                    |  |                  |                        |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                          |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                  |                        |  |  |
| Towson                                                                                                                                                                                                                                                                                                                             |  |         | St. Joseph Hospital                                                          |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                      |  |         | 13b. COUNTY                                                                  |                  |  | 13c. CITY OR TOWN                                                                                                                                        |                                 |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                  | 13e. STREET AND NUMBER |  |  |
| Maryland                                                                                                                                                                                                                                                                                                                           |  |         | Baltimore                                                                    |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  | 400 Dale Ave. #21206   |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                  |  |         | 15. MOTHER'S MAIDEN NAME                                                     |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| First Middle Last                                                                                                                                                                                                                                                                                                                  |  |         | First Middle Last                                                            |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| Russell M. Singleton                                                                                                                                                                                                                                                                                                               |  |         | Iris K. Cutlip                                                               |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)                                                                                                                                                                                                                           |  |         | 16b. SOCIAL SECURITY NO.                                                     |                  |  | 17. INFORMANT                                                                                                                                            |                                 |  | Address                                                                                      |  |                  |                        |  |  |
| No                                                                                                                                                                                                                                                                                                                                 |  |         | None                                                                         |                  |  | Russell M. Singleton                                                                                                                                     |                                 |  | 400 Dale Avenue                                                                              |  |                  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                          |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                       |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| IMMEDIATE CAUSE (a) Possible intra-cranial hemorrhage secondary to                                                                                                                                                                                                                                                                 |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 7720                                                                                                                                                                                                                                                                                                                               |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF prolonged and severe hypoxia.                                                                                                                                                                                                                                                                       |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| (b)                                                                                                                                                                                                                                                                                                                                |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                     |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| (c)                                                                                                                                                                                                                                                                                                                                |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                 |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                             |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                  |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                 |  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                           |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                 |  |                                                                                              |  |                  |                        |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from February 25 1969, to February 27 1969, that (A) (we) last saw the deceased alive on February 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |                                                                              |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                     |  |         | 22c. DATE SIGNED                                                             |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| Imelda Salanio                                                                                                                                                                                                                                                                                                                     |  |         | February 27, 1969                                                            |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                       |  |         | 22e. ADDRESS                                                                 |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| Imelda Salanio, M.D.                                                                                                                                                                                                                                                                                                               |  |         | 7620 York Road, Towson, Md. 21204                                            |                  |  |                                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                          |  |         | 23b. DATE                                                                    |                  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                 |  | 23d. LOCATION (City or Town) (County) (State)                                                |  |                  |                        |  |  |
| Burial                                                                                                                                                                                                                                                                                                                             |  |         | 2-28-1969                                                                    |                  |  | Councilman Burial                                                                                                                                        |                                 |  | Baltimore, Co. Md.                                                                           |  |                  |                        |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                               |  |         | 25a. REC'D BY REGISTRAR                                                      |                  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                               |                                 |  |                                                                                              |  |                  |                        |  |  |
| Lassahn Funeral Home 7401 Belair Road 21236                                                                                                                                                                                                                                                                                        |  |         | MAR 4 1969                                                                   |                  |  | J. Carlos Judge                                                                                                                                          |                                 |  |                                                                                              |  |                  |                        |  |  |

88120

RECEIVED

2510

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 10-67

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------|--------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                |  |                                                                              | First Middle Last                                                            |                                                                                                                                                             |                                                                                 | 2a. DATE OF DEATH<br>Month Day Year                                                     |                                                                                                 |                                    | 2b. HOUR<br>A.M.<br>P.M.                                                                     |                    |
| SARA                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              | LUELLA                                                                       |                                                                                                                                                             |                                                                                 | SMALL                                                                                   |                                                                                                 |                                    | FEBRUARY 25th, 1969                                                                          | 11:50 <sup>h</sup> |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                             |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                            |                                                                                 |                                                                                         | 6. AGE (In years last birthday)                                                                 |                                    | IF UNDER 1 YEAR<br>MONTHS DAYS                                                               |                    |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                             |  | WHITE                                                                        |                                                                              | 9-22-1885                                                                                                                                                   |                                                                                 |                                                                                         | 83 YRS.                                                                                         |                                    | IF UNDER 24 HRS.<br>HOURS MIN.                                                               |                    |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 | 9. COUNTY OF DEATH                                                                      |                                                                                                 |                                    |                                                                                              |                    |
| Orbisonia, Penna.                                                                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                             |                                                                                 | BALTIMORE COUNTY, Md.                                                                   |                                                                                                 |                                    |                                                                                              |                    |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                             |                                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                                 |                                    | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                    |
| LUTHERVILLE, MARYLAND                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              | COLLEGE MANOR NURSING HOME                                                   |                                                                                                                                                             |                                                                                 | HOUSEWIFE                                                                               |                                                                                                 |                                    |                                                                                              |                    |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                      |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN                                                               |                                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    | 13e. STREET AND NUMBER                                                                       |                    |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              | BALTIMORE                                                                    |                                                                                                                                                             |                                                                                 |                                                                                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                                    | 1210 Limekiln Rd. Balto., Md.                                                                |                    |
| 14. FATHER'S NAME<br>First Middle Last                                                                                                                                                                                                                                                                                                                                             |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| GEORGE WASHINGTON SHENEFELT                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              | PERMELIA JANE CHILCOATE                                                      |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                                         |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                             | 17. INFORMANT Address                                                           |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| no                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              | 191-10-2378-B                                                                |                                                                                                                                                             | Joseph W. Small, 111, 535 St. Francis Rd., 21204                                |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AS CKD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Days</u><br><u>Months</u><br><u>Years</u> |                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                    |                                                                                              |                    |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                           |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                              |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                       |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                                                              |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 19 67</u> to <u>Feb 25 19 69</u> , that (I) (we) last saw the deceased alive on <u>Feb 25 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 22b. SIGNATURE<br><u>RK Gundry MD</u><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                    |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 | 22c. DATE SIGNED<br><u>2-27-69</u> |                                                                                              |                    |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | 22e. ADDRESS                                                                 |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| Richard K Gundry                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              | 2 W University Pkwy 21218                                                    |                                                                                                                                                             |                                                                                 |                                                                                         |                                                                                                 |                                    |                                                                                              |                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                 |                                                                                         | 23d. LOCATION (City or Town) (County) (State)                                                   |                                    |                                                                                              |                    |
| Burial                                                                                                                                                                                                                                                                                                                                                                             |  | Feb. 27, 1969                                                                |                                                                              | Dulaney Valley Memorial                                                                                                                                     |                                                                                 |                                                                                         | Cockeysville, Md.                                                                               |                                    |                                                                                              |                    |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              | 25a. REC'D BY REGISTRAR DATE                                                                                                                                |                                                                                 | 25b. REGISTRAR'S SIGNATURE                                                              |                                                                                                 |                                    |                                                                                              |                    |
| John Burne Sore. Towson, Md.                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              | MAR 3 1969                                                                                                                                                  |                                                                                 | Richard J. Jones                                                                        |                                                                                                 |                                    |                                                                                              |                    |

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150

10150



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 02130                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                         | 02125                                                                     |                                                                                                                                                             |  |
| 1. DECEASED-NAME (Type or print)<br><b>FRANCIS CLIFTON SMINK</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                         | 2a. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1969</b> |                                                                                                                                                             |  |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                             |                                                                           | 5. DATE OF BIRTH<br><b>AUGUST 22, 1898</b>                                                                                                                  |  |
| 6. AGE (In years last birthday)<br><b>70</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                   |  | IF UNDER 1 YEAR<br>MONTHS <b>70</b> DAYS <b>00</b>                                                                      |                                                                           | IF UNDER 24 HRS.<br>HOURS <b>10</b> MIN <b>00</b>                                                                                                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                           |                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOSPITAL VETERANS ADMINISTRATION</b> |                                                                           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>LABORER- COUNTY ROADS</b>                                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>COMM.</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) (State)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>                                                                                   |                                                                           | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  |
| 13d. STREET AND NUMBER<br><b>3120 ROLLING ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| 14. FATHER'S NAME First Middle Last<br><b>M. CLIFTON XXX SMINK</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                         | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ETHEL V WEIDERMAN</b>    |                                                                                                                                                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)<br><b>WW I</b>                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>217 03 3630</b>                                                                          |                                                                           | 17. INFORMANT<br><b>Bryce Smink-9713 Holmdel St. Rd. Bethesda</b><br><b>CLINICAL RECORDS VAHOSP, FT HOWARD, MD</b> Md.                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b> |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>ARTERIOSCLEROTIC HEART DISEASE. PULMONARY EMPHYSEMA</b>                                                                                                                                                                                                                                                   |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                        |                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____                               |                                                                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                            |                                                                           | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____                                                                        |  |
| 22a. I certify that <del>xx</del> (this hospital) attended the deceased from <b>2/5/69</b> , 19____, to <b>2/10/69</b> , 19____, that <del>he</del> (we) last saw the deceased alive on <b>2/10/69</b> , 19____, and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(x)</del> (we) (did) <del>not</del> view the body after death.                                                 |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |
| 22b. SIGNATURE<br><i>Erhard J. Bunyor M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                      |  | DEGREE <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                                                                           | 22c. DATE SIGNED<br><b>2/11/69</b>                                                                                                                          |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ERHARD J. BUNYOR, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>                                                               |                                                                           |                                                                                                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 23b. DATE<br><b>2-14-69</b>                                                                                             |                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b><br><del>BAITXMORE NATIONAL</del>                                                             |  |
| 23d. LOCATION (City or Town)<br><b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | (County) _____ (State) _____                                                                                            |                                                                           |                                                                                                                                                             |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><b>ARMACOST FUNERAL HOME</b><br><b>LIBERTY HEIGHTS AVE. BAL MD.</b>                                          |                                                                           | 25a. REC'D BY REGISTRAR<br><b>FEB 17 1969</b>                                                                                                               |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>W. L. ...</i>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                         |                                                                           |                                                                                                                                                             |  |

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
JANUARY 23, 1911  
TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM THE CHIEF, BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

[Illegible text block]

[Illegible text block]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------|--|--|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                            |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                    |  |  | First<br><b>John</b>                                                                                       |  |  | Middle<br><b>SMITH</b>                                                                                                                                      |  |  | Last                                                                                            |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>7</b> Year <b>1969</b> |  |  | 2b. HOUR<br><b>8:10</b> AM     |  |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 4. RACE<br><b>White</b>                                                                                    |  |  | 5. DATE OF BIRTH<br><b>March 28, 1893</b>                                                                                                                   |  |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.                                               |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                    |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland Va.</b>                                                                                                                                                                                                                                                                                                                                                       |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore, Md.</b>                                                     |  |  |                                                                   |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                             |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Security Guard</b>                                            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Koppers Co.</b>                                         |  |  |                                                                   |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                       |  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                            |  |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>                                                                                                                    |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>10 Sherwood Rd.</b>                  |  |  |                                |  |  |
| 14. FATHER'S NAME First<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                              |  |  | Middle                                                                                                     |  |  | Last                                                                                                                                                        |  |  | 15. MOTHER'S MAIDEN NAME First<br><b>Unknown</b>                                                |  |  | Middle                                                            |  |  | Last                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)<br><b>None</b>                                                                                                                                                                                                                                              |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-7291</b>                                                             |  |  | 17. INFORMANT<br><b>Family Records</b>                                                                                                                      |  |  | Address                                                                                         |  |  |                                                                   |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Encephalomalacia, left cerebral hemisphere</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Carcinoma of lung with metastasis.</b>                                                                                                                                                                                                                                        |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                                                                   |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                               |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                 |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                         |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |  | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |  |  | City or Town                                                                                    |  |  | County                                                            |  |  | State                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/24/</b> , 19 <b>68</b> , to <b>2/7/</b> , 19 <b>69</b> , that (we) last saw the deceased alive on <b>2/7/</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                       |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
| 22b. SIGNATURE<br><b>Sam J. Misanik</b>                                                                                                                                                                                                                                                                                                                                                                                |  |  | DEGREE                                                                                                     |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>2/7/69</b>                                                               |  |  |                                                                   |  |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lawrence F. Misanik, M.D.</b>                                                                                                                                                                                                                                                                                                                                                       |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>                                                    |  |  |                                                                                                                                                             |  |  |                                                                                                 |  |  |                                                                   |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                             |  |  | 23b. DATE<br><b>Feb. 10, 1969</b>                                                                          |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dover Church Cemetery</b>                                                                                          |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Butler, Balto. Co., Md.</b>                 |  |  |                                                                   |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns' Sons, Towson, Maryland</b>                                                                                                                                                                                                                                                                                                                                                      |  |  | ADDRESS                                                                                                    |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 11 1969</b>                                                                                                          |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Judge</b>                                                 |  |  |                                                                   |  |  |                                |  |  |

02126

02126



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A12H  
30M REV 7/68

| MIDDLE                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                         |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                 | First Middle Last        |                                                                                                                                                             |                                                                                                                                                 | 2a. DATE OF DEATH                             |                                                                         |                                                                                                 | 2b. HOUR                                 |
| Roland                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                 | Earl                     |                                                                                                                                                             |                                                                                                                                                 | Smith                                         |                                                                         |                                                                                                 | M                                        |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE                                                                         |                          | 5. DATE OF BIRTH                                                                                                                                            |                                                                                                                                                 |                                               | 6. AGE (In years<br>lost birthday)                                      |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |
| Male                                                                                                                                                                                                                                                                                                                                                                                                |  | Cau.                                                                            |                          | 4-12-1911                                                                                                                                                   |                                                                                                                                                 |                                               | 57 YRS.                                                                 |                                                                                                 |                                          |
| 7a. BIRTHPLACE (State or foreign<br>country)                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?                                                    |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                                 | 9. COUNTY OF DEATH                            |                                                                         |                                                                                                 |                                          |
| Baltimore                                                                                                                                                                                                                                                                                                                                                                                           |  | U.S.A.                                                                          |                          |                                                                                                                                                             |                                                                                                                                                 | Baltimore Md.                                 |                                                                         |                                                                                                 |                                          |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                          |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                                                      |                                               |                                                                         | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |                                          |
| Middle River                                                                                                                                                                                                                                                                                                                                                                                        |  | 18 Kerria Lane                                                                  |                          |                                                                                                                                                             | Salesman                                                                                                                                        |                                               |                                                                         | Williams Const                                                                                  |                                          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE                                                                                                                                                                                                                                                                                                    |  |                                                                                 | 13b. COUNTY              |                                                                                                                                                             |                                                                                                                                                 | 13c. CITY OR TOWN                             |                                                                         | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                          |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                 | Baltimore                |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         | 18 Kerria Lane 21220                                                                            |                                          |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                 | 15. MOTHER'S MAIDEN NAME |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| First Middle Last                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                 | First Middle Last        |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| Bernard S. Smith                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                 | Nellie E. Llewellyn      |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                 |  |                                                                                 | 16b. SOCIAL SECURITY NO. |                                                                                                                                                             | 17. INFORMANT Address                                                                                                                           |                                               |                                                                         |                                                                                                 |                                          |
| No                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                 | 217-09-1330              |                                                                                                                                                             | Mrs Marie L. Smith 18 Kerria Lane 21220                                                                                                         |                                               |                                                                         |                                                                                                 |                                          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>Carcinoma of Sacrum, metastatic</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>4 years</u>              |                                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                 |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                          |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                       |                                               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                                                                                 |                                          |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 19, 1967</u> , to <u>Feb 11, 1969</u> , that (I) (we) last<br>saw the deceased alive on <u>Feb 10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                            |  |                                                                                 |                          |                                                                                                                                                             |                                                                                                                                                 |                                               |                                                                         |                                                                                                 |                                          |
| 22b. SIGNATURE<br><u>Emory J. Linder, M.D.</u>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                 |                          |                                                                                                                                                             | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |                                               | 22c. DATE SIGNED<br><u>Feb 11, 1969</u>                                 |                                                                                                 |                                          |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><u>Dr. Emory J. Linder</u>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                 |                          |                                                                                                                                                             | 22e. ADDRESS<br><u>902 Averill Road Joppa, Md. 21085</u>                                                                                        |                                               |                                                                         |                                                                                                 |                                          |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE                                                                       |                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                                                                                 | 23d. LOCATION (City or Town) (County) (State) |                                                                         |                                                                                                 |                                          |
| Burial                                                                                                                                                                                                                                                                                                                                                                                              |  | 2-1301969                                                                       |                          | LakeView Memorial Cem.                                                                                                                                      |                                                                                                                                                 | Baltimore Co. Md.                             |                                                                         |                                                                                                 |                                          |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                 |                          |                                                                                                                                                             | 25a. REC'D BY REGISTRAR                                                                                                                         |                                               | 25b. REGISTRAR'S SIGNATURE                                              |                                                                                                 |                                          |
| Lassahn Funeral Home 7401 Belaire Road 21236                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                 |                          |                                                                                                                                                             | DATE <u>FEB 13 1969</u>                                                                                                                         |                                               | <u>[Signature]</u>                                                      |                                                                                                 |                                          |

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903

1-1-1903



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------|-------|--------------------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                   |  | First<br><b>JOHN</b>                                                                                      |  | Middle<br><b>Henery</b>                                                                                                                                     |  | Last<br><b>SNOW</b>                                                                                        |                                                                                  | 2a. DATE OF DEATH<br>Month<br><b>FEBRUARY</b> Day<br><b>1</b> , Year<br><b>1969</b> |                                                        |       | 2b. HOUR<br><b>8:57 a.m.</b>                           |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><b>WHITE</b>                                                                                   |  | 5. DATE OF BIRTH<br><b>APRIL 7, 1903</b>                                                                                                                    |  |                                                                                                            | 6. AGE (In years last birthday)<br><b>65</b> YRS.                                |                                                                                     | IF UNDER 1 YEAR<br>MONTHS<br><b>1</b> DAYS<br><b>1</b> |       | IF UNDER 24 HRS.<br>HOURS<br><b>1</b> MIN<br><b>57</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                           |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                     |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON 4</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST JOSEPH HOSPITAL</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Watchman</b> |                                                                                  |                                                                                     | 12b. KIND OF BUSINESS OR INDUSTRY                      |       |                                                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>Salisbury</b>                                                                           |  | 13c. CITY OR TOWN<br><b>#21030 COCKEYSVILLE</b>                                                                                                             |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |                                                                                  | 13e. STREET AND NUMBER<br><b>21 BOSLEY AVENUE</b>                                   |                                                        |       |                                                        |
| 14. FATHER'S NAME First<br><b>Millard</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  | Middle<br><b>Snow</b>                                                                                     |  | Last<br><b>unknown</b>                                                                                                                                      |  | 15. MOTHER'S MAIDEN NAME First<br><b>unknown</b>                                                           |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                       |  | (If yes give war or dates of service)                                                                     |  | 16b. SOCIAL SECURITY NO.<br><b>229-12-5626</b>                                                                                                              |  | 17. INFORMANT Address<br><b>Mrs. Vera A. Snow Same as # 13 E</b>                                           |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular heart disease</b><br><b>412 4</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                                                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                |                                                        |       |                                                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |  | City or Town                                                                                               |                                                                                  | County                                                                              |                                                        | State |                                                        |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 31, 1969</b> , to <b>FEB 1, 1969</b> , that (I) (we) last saw the deceased alive on <b>FEB. 1, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 22b. SIGNATURE<br><b>Lilia C. Baldonado</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED<br><b>FEB 1, 1969</b>                                                                                                                                                                                                                             |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Lilia C. Baldonado, M. D.</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 22e. ADDRESS<br><b>7620 YORK ROAD, TOWSON 4, MD.</b>                                                                                                        |  |                                                                                                            |                                                                                  |                                                                                     |                                                        |       |                                                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>2-5-69</b>                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Elizabeth Cemetery</b>                                                                                             |  |                                                                                                            | 23d. LOCATION (City or Town) (County) (State)<br><b>Saltville Smyth Virginia</b> |                                                                                     |                                                        |       |                                                        |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson Inc. Towson, Md. 21204</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 4 1969</b>                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                           |                                                                                  |                                                                                     |                                                        |       |                                                        |

08180

08180

NAME

DATE

TIME

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

08180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02134</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02129</div>                                                                                                                                                                                                        |  |                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LILLIAN K. SOLOMON</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                               |  | 2a. DATE OF DEATH<br><b>2</b> Month <b>3</b> Day <b>69</b> Year                                                                                             |  |                                                                                    |  | 2b. HOUR<br><b>6:20</b> P                    |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br><b>CAUCASIAN</b>                                                                                   |  | 5. DATE OF BIRTH<br><b>9-19-1894</b>                                                                                                                        |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                         |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREAT. BALT. MED. CENT</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                  |  |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                               |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                                         |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |  | 13e. STREET AND NUMBER<br><b>1107 Ramblewood Road</b>                              |  |                                              |  |
| 14. FATHER'S NAME First Middle Last<br><b>Benjamin Horn</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                               |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Margaret Hammel</b>                                                                                        |  |                                                                                    |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                        |  | 16b. SOCIAL SECURITY NO.<br><b>215-34-8614</b>                                                                |  | 17. INFORMANT<br><b>Mrs. Katherine Keyes</b>                                                                                                                |  | Address<br><b>Same</b>                                                             |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CARCINOMA OF BOWEL WITH METASTASIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                             |  |                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                              |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                    |  |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                    |  |                                              |  |
| 22a. I certify that <b>1</b> (this hospital) attended the deceased from <b>1-17-</b> , 19 <b>69</b> , to <b>2-3</b> , 19 <b>69</b> , that <b>1</b> (we) last saw the deceased alive on <b>2-3</b> , 19 <b>69</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>1</b> (we) (did) <b>not</b> view the body after death.                          |  |                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
| 22b. SIGNATURE<br><b>Chang Lin M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                                                                 |  |                                                                                                               |  |                                                                                                                                                             |  |                                                                                    |  | 22c. DATE SIGNED<br><b>Jan. Feb. 3. 1969</b> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>CHANG LIN, M.D.</b>                                                                                                                                                                                                                                                                                                                                                         |  | 22e. ADDRESS<br><b>6701 N CHARLES ST</b>                                                                      |  |                                                                                                                                                             |  |                                                                                    |  |                                              |  |
| 23a. BURIAL, CREMATION, or other disposition (specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE<br><b>2/7/69</b>                                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>                                                                                           |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>         |  |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                               |  | 25a. REC'D BY REGISTRAR<br><b>FEB 4 1969</b>                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |                                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-60)  
30M REV. 1-69

| <div>02135</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02130</div>                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                  |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                   | 2a. DATE OF DEATH                                                                                                               |                                                                      |                            | 2b. HOUR                                     |
| Anna                                                                                                                                                                                                                                                                                                 |  |                                                                              | M Soul                                                                       |                                                                                                                                                          |                                                                                   | Month 2 Day 15 Year 69                                                                                                          |                                                                      |                            | 9:15A M                                      |
| 3. SEX                                                                                                                                                                                                                                                                                               |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                   |                                                                                                                                 | 6. AGE (In years lost birthday)                                      |                            | IF UNDER 1 YEAR MONTHS DAYS                  |
| Female                                                                                                                                                                                                                                                                                               |  | White                                                                        |                                                                              | July 26, 1883                                                                                                                                            |                                                                                   |                                                                                                                                 | 85 YRS.                                                              |                            | IF UNDER 24 HRS. HOURS MIN                   |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                                                              |                                                                      |                            |                                              |
| Maryland                                                                                                                                                                                                                                                                                             |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                          |                                                                                   | Baltimore Md.                                                                                                                   |                                                                      |                            |                                              |
| 10. CITY OR TOWN OF DEATH.                                                                                                                                                                                                                                                                           |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                         |                                                                      |                            | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Perry Hall                                                                                                                                                                                                                                                                                           |  |                                                                              | 8912 Mavis Ave                                                               |                                                                                                                                                          |                                                                                   | Housewife                                                                                                                       |                                                                      |                            |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE                                                                                                                                                                                                         |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                                                                      | 13e. STREET AND NUMBER     |                                              |
| Maryland                                                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          | Baltimore                                                                         |                                                                                                                                 |                                                                      | 904 North Bradford St      |                                              |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                  |  |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| John Svec                                                                                                                                                                                                                                                                                            |  |                                                                              | Marie Klima                                                                  |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)                                                                                                                                                                                               |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT                                                                     |                                                                                                                                 | Address                                                              |                            |                                              |
| No                                                                                                                                                                                                                                                                                                   |  |                                                                              | 213-12-6100                                                                  |                                                                                                                                                          | Mr Joseph H Soul                                                                  |                                                                                                                                 | Same                                                                 |                            |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                            |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency                                                                                                                                                                                                                            |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            | Hours                                        |
| 4122 DUE TO, OR AS A CONSEQUENCE OF (b) Senile Arteriosclerosis                                                                                                                                                                                                                                      |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            | Years                                        |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Aging & Hypertension (ESS)                                                                                                                                         |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                            |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/2, 19 67, to 2/15, 19 69, that (I) (we) lost the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                                                                 |                                                                      |                            |                                              |
| 22b. SIGNATURE Juan F. Sordo M.D. M.D. DEGREE                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                      | 22c. DATE SIGNED 2/15/69   |                                              |
| 22d. PHYSICIAN'S NAME (Type) Juan F. Sordo M.D.                                                                                                                                                                                                                                                      |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   | 22e. ADDRESS 605 Hillen Rd Baltimore, Md 21204                                                                                  |                                                                      |                            |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                            |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                   | 23d. LOCATION (City or Town) (County) (State)                                                                                   |                                                                      |                            |                                              |
| Burial                                                                                                                                                                                                                                                                                               |  | 2/18/69                                                                      |                                                                              | Holy Redeemer                                                                                                                                            |                                                                                   | Baltimore, Maryland                                                                                                             |                                                                      |                            |                                              |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   | 25a. REC'D BY REGISTRAR DATE                                                                                                    |                                                                      | 25b. REGISTRAR'S SIGNATURE |                                              |
| Leonard J Ruck Inc. Baltimore, Maryland                                                                                                                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   | FEE 19 1969                                                                                                                     |                                                                      | J. Sordo                   |                                              |

03130

MINUTE OF STATE

03130

03130

X

1.1.1

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02136</div> <div> <div>MD</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02131</div> </div>                                                                                                                                                                                                             |  |                     |                                                                                                         |                                           |  |                                                                                                                                                             |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Mary Ella Stachnick</b>                                                                                                                                                                                                                                                                                                                                  |  |                     |                                                                                                         |                                           |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>1</b> Year <b>1969</b>                                                                                    |                                                   |  | 2b. HOUR<br><b>7:15 AM</b>                                                                      |                                                              |                                             |                                                           |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 4. RACE<br><b>W</b> |                                                                                                         | 5. DATE OF BIRTH<br><b>August 5, 1895</b> |  |                                                                                                                                                             | 6. AGE (In years last birthday)<br><b>73</b> YRS. |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>73</b> DAYS <b>73</b>                                           |                                                              | 8. IF UNDER 24 HRS.<br>HOURS <b>73</b> MIN. |                                                           |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Co.</b>                                                                                                                                                                                                                                                                                                                                  |  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                           |                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                   |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |                                                              |                                             |                                                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hydes, Md.</b>                                                                                                                                                                                                                                                                                                                                                  |  |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Box 68 Record Rd</b> |                                           |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>                                           |                                                              |                                             |                                                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                     |  |                     | 13b. COUNTY<br><b>Baltimore</b>                                                                         |                                           |  | 13c. CITY OR TOWN<br><b>Hydes</b>                                                                                                                           |                                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                              |                                             | 13e. STREET AND NUMBER<br><b>Box 68 Record Road 21082</b> |  |
| 14. FATHER'S NAME<br>First <b>Washington</b> Middle <b>Ruff</b> Last <b>Lee</b>                                                                                                                                                                                                                                                                                                                 |  |                     |                                                                                                         |                                           |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Lora</b> Middle <b>Lee</b> Last <b>Lee</b>                                                                             |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                            |  |                     | 16b. SOCIAL SECURITY NO.<br><b>213-30-7007</b>                                                          |                                           |  | 17. INFORMANT<br><b>Frederick Deckert</b>                                                                                                                   |                                                   |  | Address<br><b>Box 68 Hydes Md. 21082</b>                                                        |                                                              |                                             |                                                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                     |                                                                                                         |                                           |  |                                                                                                                                                             |                                                   |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs</b> |                                             |                                                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>None</b>                                                                                                                                                                                                                                               |  |                     |                                                                                                         |                                           |  |                                                                                                                                                             |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                          |  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |                                           |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |                                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                                              |                                             |                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                        |  |                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |                                           |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)                                                                              |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                  |  |                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |                                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1969</b> , to <b>Feb. 1, 1969</b> , that (I) (we) last saw the deceased alive at <b>4 AM on Feb. 1, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                           |  |                     |                                                                                                         |                                           |  |                                                                                                                                                             |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
| 22b. SIGNATURE<br><b>Phyllis K. Pullen</b> M.D. DEGREE                                                                                                                                                                                                                                                                                                                                          |  |                     |                                                                                                         |                                           |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |                                                   |  | 22c. DATE SIGNED<br><b>2/1/69</b>                                                               |                                                              |                                             |                                                           |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Phyllis K. Pullen</b>                                                                                                                                                                                                                                                                                                                                        |  |                     |                                                                                                         |                                           |  | 22e. ADDRESS<br><b>Box 381 Jerusalem Road Kingsville Md.</b>                                                                                                |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                      |  |                     | 23b. DATE<br><b>2-4-1969</b>                                                                            |                                           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>                                                                                             |                                                   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore City Md.</b>                      |                                                              |                                             |                                                           |  |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>                                                                                                                                                                                                                                                                                                                                             |  |                     |                                                                                                         |                                           |  | ADDRESS<br><b>7401 Belair Road 21236</b>                                                                                                                    |                                                   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 5 1969</b>                                               |                                                              |                                             |                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                 |  |                     |                                                                                                         |                                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                            |                                                   |  |                                                                                                 |                                                              |                                             |                                                           |  |

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1  
45M

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                    |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                            |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 02137                                                                                                                                                                                                                                                                                                  |  |                              |                                                                              |                                                                                                                                                          | 02132                              |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                       |  |                              |                                                                              |                                                                                                                                                          | 2a. DATE OF DEATH                  |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| Emil Lawrence James Stakem                                                                                                                                                                                                                                                                             |  |                              |                                                                              |                                                                                                                                                          | 2 Month 11 Day 69 Year 11:05 PM    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                 |  | 4. RACE                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                    |                                                                                         | 6. AGE (In years lost birthday) |                                                                                   | IF UNDER 1 YEAR MONTHS DAYS                                          |                                              |  |
| Male                                                                                                                                                                                                                                                                                                   |  | White                        |                                                                              | Maryland 9-5-06                                                                                                                                          |                                    |                                                                                         | 62 YRS.                         |                                                                                   | IF UNDER 24 HRS. HOURS MIN                                           |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |                                                                                         | 9. COUNTY OF DEATH              |                                                                                   |                                                                      |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                               |  | U.S.                         |                                                                              |                                                                                                                                                          |                                    |                                                                                         | Baltimore County Md.            |                                                                                   |                                                                      |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                              |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                              |  |
| Randallstown                                                                                                                                                                                                                                                                                           |  |                              | Balto. Co. Gen. Hospital                                                     |                                                                                                                                                          |                                    | Construction                                                                            |                                 |                                                                                   | Inter Co. (Con.)                                                     |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                          |  |                              |                                                                              | 13b. COUNTY                                                                                                                                              |                                    | 13c. CITY OR TOWN                                                                       |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER                       |  |
| Md.                                                                                                                                                                                                                                                                                                    |  |                              |                                                                              | Balto.                                                                                                                                                   |                                    | Baltimore                                                                               |                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                                                      | 7015 Yataruba Dr.                            |  |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                    |  |                              |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                                                                                               |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| James B. Stakem                                                                                                                                                                                                                                                                                        |  |                              |                                                                              | Theresa Sharp                                                                                                                                            |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)                                                                                                                                                                                               |  |                              |                                                                              | 16b. SOCIAL SECURITY NO.                                                                                                                                 |                                    | 17. INFORMANT Address                                                                   |                                 |                                                                                   |                                                                      |                                              |  |
| no                                                                                                                                                                                                                                                                                                     |  |                              |                                                                              | 212-12-8581                                                                                                                                              |                                    | Mrs. Margaret C. Stakem-7015 Yataruba Dr.                                               |                                 |                                                                                   |                                                                      |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))                                                                                                                                                                                                                               |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction                                                                                                                                                                                                                           |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis                                                                                                                                                                                                                                                |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                      |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebro Vascular Accident                                                                                                                                          |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                 |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                                                          |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                 |                                                                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |  |
|                                                                                                                                                                                                                                                                                                        |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                     |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                                                                                                          |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                 |                                                                                   |                                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                        |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                               |  |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                                                                                                                                          |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                 |                                                                                   |                                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                        |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11/69, to 2/11/69, that (I) (we) last saw the deceased alive on 2/11/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                         |  |                              | 22c. PHYSICIAN'S NAME (Type)                                                 |                                                                                                                                                          |                                    | 22d. ADDRESS                                                                            |                                 |                                                                                   | 22e. DATE SIGNED                                                     |                                              |  |
| G. Taylor, MD                                                                                                                                                                                                                                                                                          |  |                              | G. Taylor                                                                    |                                                                                                                                                          |                                    | 22d. ADDRESS                                                                            |                                 |                                                                                   | 2/11/69                                                              |                                              |  |
| 22d. ADDRESS                                                                                                                                                                                                                                                                                           |  |                              | 22e. DATE SIGNED                                                             |                                                                                                                                                          |                                    | 22f. SIGNATURE                                                                          |                                 |                                                                                   | 22g. DATE SIGNED                                                     |                                              |  |
|                                                                                                                                                                                                                                                                                                        |  |                              |                                                                              |                                                                                                                                                          |                                    |                                                                                         |                                 |                                                                                   |                                                                      |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                              |  |                              | 23b. DATE                                                                    |                                                                                                                                                          | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                         |                                 | 23d. LOCATION (City or Town) (County) (State)                                     |                                                                      |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                 |  |                              | Feb. 15, 1969                                                                |                                                                                                                                                          | Lake View Memorial                 |                                                                                         |                                 | Liberty Rd. Carroll Md.                                                           |                                                                      |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                   |  |                              | 24b. ADDRESS                                                                 |                                                                                                                                                          |                                    | 25a. REC'D BY REGISTRAR                                                                 |                                 |                                                                                   | 25b. REGISTRAR'S SIGNATURE                                           |                                              |  |
| John S. Stansbury                                                                                                                                                                                                                                                                                      |  |                              | 6414 Wilson Rd                                                               |                                                                                                                                                          |                                    | DATE FEB 13 1969                                                                        |                                 |                                                                                   | J. Charles Jones                                                     |                                              |  |

28150

1936 10 10 11 11 11

70122

28150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02138

02133

|                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Ruby</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |  | First Middle Last                                                                                          |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>13</b> Year <b>1969</b>                                                                                          |  |  | 2b. HOUR<br><b>4:45</b> M                                                                    |                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 4. RACE<br><b>Negro</b>                                                                                    |  |  | 5. DATE OF BIRTH<br><b>12-10-16</b>                                                                                                                         |  |  | 6. AGE (In years last birthday)<br><b>52</b> YRS.                                            |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                      |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.                                                  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                   |  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                            |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Lindsay Burgess</b>                                                                                                                                                                                                                                                                                                                                                                  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Missouri Hickman</b>                                   |  |  | 13e. STREET AND NUMBER<br><b>2116 Llewellyn Ave.</b>                                                                                                        |  |  |                                                                                              |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>                                                                                                                                                                                                                                                                                                                                                       |  |  | 16b. SOCIAL SECURITY NO.<br><b>131</b>                                                                     |  |  | 17. INFORMANT<br><b>Thomas Staples</b>                                                                                                                      |  |  | Address<br><b>2116 Llewellyn Ave.</b>                                                        |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Advanced carcinomatosis of abdomen</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Primary site - adenocarcinoma of colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                          |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                          |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                              |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                    |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                              |                                              |  |
| 22a. I certify that (A) (this hospital) attended the deceased from <b>10/28/</b> , 19 <b>68</b> , to <b>2/13/</b> , 19 <b>69</b> , that (A) (we) last saw the deceased alive on <b>2/13/</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                            |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                              |                                              |  |
| 22b. SIGNATURE<br><b>Lucas Vidhyaphum</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                            |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>2/13/69</b>                                                           |                                              |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Lucas Vidhyaphum, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                            |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>                                                                                                     |  |  |                                                                                              |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                        |  |  | 23b. DATE<br><b>2-17-69</b>                                                                                |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cemetery</b>                                                                                           |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Anne Arundel Co. Md.</b>                 |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>Randolph J. Collick</b>                                                                                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                            |  |  | 25a. REC'D BY REGISTRAR<br><b>2431 E. Oliver St.</b>                                                                                                        |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Baltimore, Md. 21213</b>                                    |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                            |  |  | DATE<br><b>FEB 18 1969</b>                                                                                                                                  |  |  |                                                                                              |                                              |  |

05130

05130

05130





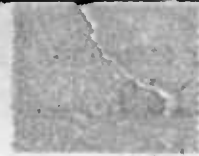
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02139 CERTIFICATE OF DEATH 02134

|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND                                                                                                                                                                                                                                                                         |  |                                                                                                           |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |  |                                                                               |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>                                                                                                                                                                                                                                |  |                                                                                                           |  | c. LENGTH OF STAY IN 1b<br><u>Towson</u>                                                                                                                    |  |                                                                               |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Chesapeake Manor Nursing Home</u>                                                                                                                                                                                                             |  |                                                                                                           |  | d. STREET ADDRESS<br><u>501 Park Avenue</u>                                                                                                                 |  |                                                                               |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edna</u> Middle <u>Pyburn</u> Last <u>Stebbins</u>                                                                                                                                                                                                                               |  |                                                                                                           |  | 4. DATE OF DEATH<br>Month <u>February</u> Day <u>15</u> Year <u>1969</u>                                                                                    |  |                                                                               |  |
| 5. SEX<br><u>Female</u>                                                                                                                                                                                                                                                                                                          |  | 6. COLOR OR RACE<br><u>White</u>                                                                          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>March 24, 1887</u>                                     |  |
| 9. AGE (In years last birthday)<br><u>81</u> yrs.                                                                                                                                                                                                                                                                                |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                                                        |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>                                                                                                          |  |                                                                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>                                                                                                                                                                                                                  |  |                                                                                                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>                                                                                                        |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ontario, Canada</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                               |  |
| 13. FATHER'S NAME<br><u>John Pyburn</u>                                                                                                                                                                                                                                                                                          |  |                                                                                                           |  | 14. MOTHER'S MAIDEN NAME<br><u>Agnes Bone</u>                                                                                                               |  |                                                                               |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>                                                                                                                                                                                                                                                   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>                                                                    |  | 17. INFORMANT<br><u>Family Records</u>                                                                                                                      |  |                                                                               |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u><br><u>437.9</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u><br>DUE TO (c) <u>  </u> |  |                                                                                                           |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u>                                                                                                          |  |                                                                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                               |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                            |  |                                                                                                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                |  |                                                                               |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>                                                                                                                                                                                                                                                    |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                      |  | 20f. (City or town) (County) (State)                                          |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June, 1963</u> to <u>2/15, 1969</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> 19 <u>69</u> , and that death occurred at <u>5:20</u> p.m. from the causes and on the date stated above.                                                     |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                               |  |
| 22a. SIGNATURE<br><u>Franklin E. Leslie</u>                                                                                                                                                                                                                                                                                      |  |                                                                                                           |  | 22b. DATE SIGNED<br><u>2/18/69</u>                                                                                                                          |  |                                                                               |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Franklin E. Leslie, M. D.</u>                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 22d. ADDRESS<br><u>3501 St. Paul St. 21218</u>                                                                                                              |  |                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                       |  | 23b. DATE THEREOF<br><u>Feb. 18, 1969</u>                                                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Dulaney Valley Memorial</u>                                                                                        |  | 23d. LOCATION (City, town or county) (State)<br><u>Cockeysville, Maryland</u> |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns Sons, Towson, Maryland</u>                                                                                                                                                                                                                                                                 |  |                                                                                                           |  | 25a. REC'D BY REGISTRAR<br><u>FEB 20 1969</u>                                                                                                               |  |                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                                                                                          |  |                                                                               |  |

10130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1214  
30M REV 1-69

| <div style="display: flex; justify-content: space-between;"> <span>02140</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02135</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>                                                                                                |  |                                                  |                                                                                                         |                                                                                                                                                             |                                                                                                                                 |                                                                                                             |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------|-------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                  | First<br><b>JOSEPHINE</b>                                                                               |                                                                                                                                                             | Middle<br><b>A</b>                                                                                                              |                                                                                                             | Last<br><b>STEFAN</b>                                                     |                                                                                                 | 2a. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>21</b> Year <b>1969</b> |                                                                            | 2b. HOUR<br><b>M</b>                          |       |
| 3. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>white</b>                          |                                                                                                         | 5. DATE OF BIRTH<br><b>1/19/94</b>                                                                                                                          |                                                                                                                                 |                                                                                                             | 6. AGE (In years last birthday)<br><b>75</b> YRS.                         |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                        |                                                                            | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Baltimore</b> |                                                                                                         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                 | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                  |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 10. CITY OR TOWN OF DEATH<br><b>Chesapeake Manor</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>309 E. Joppa Rd.</b> |                                                                                                                                                             |                                                                                                                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |                                                                           |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>                   |                                                                            |                                               |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                 |  |                                                  | 13b. COUNTY<br><b>Baltimore</b>                                                                         |                                                                                                                                                             |                                                                                                                                 | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                       |                                                                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                       | 13e. STREET AND NUMBER<br><b>2315 Ashland Ave. 21205</b>                   |                                               |       |
| 14. FATHER'S NAME First<br><b>Henry</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                  | Middle<br><b>Zavadil</b>                                                                                |                                                                                                                                                             |                                                                                                                                 | Last<br><b>unknown</b>                                                                                      |                                                                           |                                                                                                 | 15. MOTHER'S MAIDEN NAME First<br><b>unknown</b>                      |                                                                            |                                               |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                                                       |  |                                                  | 16b. SOCIAL SECURITY NO.<br><b>215-09-3334D</b>                                                         |                                                                                                                                                             |                                                                                                                                 | 17. INFORMANT Address<br><b>James Stefan, son, 2315 Ashland Ave.</b>                                        |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                              |  |                                                  |                                                                                                         |                                                                                                                                                             |                                                                                                                                 |                                                                                                             |                                                                           |                                                                                                 |                                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 month</b><br><b>?</b> |                                               |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                          |  |                                                  |                                                                                                         |                                                                                                                                                             |                                                                                                                                 |                                                                                                             |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                        |                                                                                                                                                             |                                                                                                                                 |                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                                                            |                                               |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                    |  |                                                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |                                                                                                                                                             |                                                                                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                              |  |                                                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |                                                                                                                                                             |                                                                                                                                 | 21f. LOCATION Street or R.F.D. No.                                                                          |                                                                           | City or Town                                                                                    |                                                                       | County                                                                     |                                               | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> , 19 <b>69</b> , to <b>Feb 22</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>Feb 20</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |                                                  |                                                                                                         |                                                                                                                                                             |                                                                                                                                 |                                                                                                             |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 22b. SIGNATURE<br><b>Sylvan D. Goldberg</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                  | DEGREE                                                                                                  |                                                                                                                                                             | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                                             | 22c. DATE SIGNED<br><b>2/24/69</b>                                        |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Sylvan Goldberg</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                  | 22e. ADDRESS<br><b>Medical Arts Bldg.</b>                                                               |                                                                                                                                                             |                                                                                                                                 |                                                                                                             |                                                                           |                                                                                                 |                                                                       |                                                                            |                                               |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                  | 23b. DATE<br><b>2/25/69</b>                                                                             |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>                                                                 |                                                                                                             |                                                                           | 23d. LOCATION (City or Town)<br><b>Baltimore, Md.</b>                                           |                                                                       | (County) (Store)                                                           |                                               |       |
| 24. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b><br><b>2601 E. Madison St.</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                  |                                                                                                         |                                                                                                                                                             |                                                                                                                                 | 25a. RECEIVED BY REGISTRAR<br>DATE<br><b>FEB 25 1969</b>                                                    |                                                                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                              |                                                                       |                                                                            |                                               |       |

MEDICAL CERTIFICATION

55120

1950

• • •

3

## Findings

• • •

01-22-2015

1992 6 5 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-58

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 1. DECEASED-NAME<br>(Type or print) <b>Gwladys Hogan Stickney</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>17</b> Year <b>1969</b>                       |                                                                        |                                                          | 2b. HOUR<br><b>3:45 AM</b>                            |                                                                            |                                                |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>W</b>                                                                                               |  | 5. DATE OF BIRTH<br><b>March 7, 1889</b>                                                                                                                    |                                                                                                             |                                                                                                 | 6. AGE (In years lost birthday)<br><b>79</b> YRS.                      |                                                          | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>        |                                                                            | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>St. Louis, Mo.</b>                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                             | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                      |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>College Manor Nursing Home</b> |  |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |                                                                                                 |                                                                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>     |                                                       |                                                                            |                                                |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY<br><b>Baltimore</b>                                                                                   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                                                                                                       |                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                        | 13e. STREET AND NUMBER<br><b>104 W. University Pkwy.</b> |                                                       |                                                                            |                                                |
| 14. FATHER'S NAME First <b>Robert</b> Middle <b>G.</b> Last <b>Hogan</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME First <b>Cornelia S.</b> Middle <b>Heslep</b> Last <b></b>                                                                         |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMY FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.<br><b></b>                                                                               |  | 17. INFORMANT Address<br><b>Dr. George L. Stickney (Same)</b>                                                                                               |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b><br><b>4379</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 mo</b><br><b>2 yr</b> |                                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                               |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                  |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                                          |                                                       |                                                                            |                                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b><br>P.M. <b></b>                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>                                                                |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/2/63</b> to <b>2/17/69</b> , that (I) (we) lost saw the deceased alive on <b>Feb 16 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.                                                                                   |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 22b. SIGNATURE<br><b>Norman R. Freeman, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                   |  |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       | 22c. DATE SIGNED<br><b>2/17/69</b>                                         |                                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Norman R. Freeman, Jr.</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                   |  | 22e. ADDRESS<br><b>11 W. 29th St.</b>                                                                                                                       |                                                                                                             |                                                                                                 |                                                                        |                                                          |                                                       |                                                                            |                                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><b>2/19/1969</b>                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>                                                                                                    |                                                                                                             |                                                                                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |                                                          |                                                       |                                                                            |                                                |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                   |  | ADDRESS<br><b>4905 York Rd. Balto. 12, Md.</b>                                                                                                              |                                                                                                             |                                                                                                 | 25a. REC'D BY REGISTRAR<br><b>FEB 18 1969</b>                          |                                                          | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Yager</b> |                                                                            |                                                |

1. *Staphylococcus aureus* (100%)

1993-1994 2005-2006 2007-2008 2009-2010 2011-2012

... ..

• • • • •



## CERTIFICATE OF DEATH

02142

02137

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                        |                                                                           |                                                                                                                                                             |  |                                                                                              |                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>LILIOSE Devitt STUART</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>28</b> Year <b>1969</b> |                                                                                                                                                             |  | 2b. HOUR<br><b>12:30 P M</b>                                                                 |                                                                                             |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                |                                                                           | 5. DATE OF BIRTH<br><b>20 March 1910</b>                                                                                                                    |  | 6. AGE (If years last birthday)<br><b>58</b> YRS.                                            |                                                                                             |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Biloxi Mississippi</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                             |                                                                           | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                   |                                                                                             |
| 10. CITY OR TOWN OF DEATH<br><b>Phoenix</b>                                                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Carroll Mill Rd</b> |                                                                           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Teacher</b>                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Same</b>                                             |                                                                                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Ind</b>                                                                                                                                                                                                                                                                                                                               |  | 13b. COUNTY<br><b>Balto</b>                                                                            |                                                                           | 13c. CITY OR TOWN<br><b>Phoenix</b>                                                                                                                         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                             |
| 13e. STREET AND NUMBER<br><b>Carroll Mill Rd</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                        |                                                                           |                                                                                                                                                             |  |                                                                                              |                                                                                             |
| 14. FATHER'S NAME First Middle Last<br><b>Matthew Devitt</b>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                        | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Lilly Bowdoin</b>        |                                                                                                                                                             |  |                                                                                              |                                                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                             |  | 16b. SOCIAL SECURITY NO.<br><b>2-18-01-0747</b>                                                        |                                                                           | 17. INFORMANT<br><b>Husband</b>                                                                                                                             |  | Address<br><b>Same</b>                                                                       |                                                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sino Cardiac Infarction</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardio Vascular Disease</b>          |  |                                                                                                        |                                                                           |                                                                                                                                                             |  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b><br><b>1961</b><br><b>1960</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                        |  |                                                                                                        |                                                                           |                                                                                                                                                             |  |                                                                                              |                                                                                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                       |                                                                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                                                                             |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                             |                                                                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                              |                                                                                             |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |                                                                           | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                              |                                                                                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 25</b> , 19 <b>69</b> , to <b>Feb 28</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Feb 25</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death. |  |                                                                                                        |                                                                           |                                                                                                                                                             |  |                                                                                              |                                                                                             |
| 22b. SIGNATURE<br><b>Walter T. Kees</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br><b>MD</b>                                                                                    |                                                                           | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>28 Feb 1969</b>                                                       |                                                                                             |
| 22d. PHYSICIAN'S NAME (Type)<br><b>WALTER T. KEES</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 22e. ADDRESS<br><b>Cockeyville Ind</b>                                                                 |                                                                           |                                                                                                                                                             |  |                                                                                              |                                                                                             |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>2-28-69</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>2-28-69</b>                                                                            |                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>C. of Med. Med. School</b>                                                                                         |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Ind.</b>                      |                                                                                             |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                      |  | ADDRESS                                                                                                |                                                                           | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 4 1969</b>                                                                                                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                           |                                                                                             |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1012

REPUBLIC OF ALGERIA

1012



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                            |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                            |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 1. DECEASED-NAME (Type or print) <b>Edgar</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                            | First <b>F.</b> Middle <b>Stultz</b> Last                                            |                                                                                                                                                          |  | 2a. DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>1969</b>                            |  | 2b. HOUR <b>11 a</b>                                    |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE <b>White</b>                                                                                       |                                                                                      | 5. DATE OF BIRTH <b>Oct. 27, 1894</b>                                                                                                                    |  | 6. AGE (In years last birthday) <b>74</b> YRS.                                               |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                 |                                                                                      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.                                                      |  |                                                         |  |
| 10. CITY OR TOWN OF DEATH <b>Owings Mills</b>                                                                                                                                                                                                                                                                                                                                                                                                            |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>11015 Reisterstown Rd.</b> |                                                                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mechanic</b>                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>                                              |  |                                                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                            |  | 13b. COUNTY <b>Baltimore</b>                                                                               |                                                                                      | 13c. CITY OR TOWN <b>Owings Mills</b>                                                                                                                    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>11015 Reisterstown Rd.</b>    |  |
| 14. FATHER'S NAME First <b>George</b> Middle <b>Stultz</b> Last                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                            | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Catherine</b> Last <b>Bloom</b> |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 16b. SOCIAL SECURITY NO. <b>215-10-3949</b>                                                                |                                                                                      | 17. INFORMANT <b>Mrs. Marie Stultz</b>                                                                                                                   |  | Address <b>11015 Reisterstown Rd. Owings Mills, Md.</b>                                      |  |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of Prostate with metastasis</b><br><b>185X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> |  |                                                                                                            |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                       |  |                                                                                                            |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |                                                                                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.                                                |                                                                                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                                              |  |                                                         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work                                                                                                                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                                                                                      | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                                              |  |                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>Feb 3</b> , 19 <b>69</b> , that (I) ( <b>we</b> ) last saw the deceased alive on <b>Feb 3</b> , 19 <b>69</b> , and that in ( <b>my</b> ) ( <b>our</b> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <b>we</b> ) (did) (did not) view the body after death.                                                 |  |                                                                                                            |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 22b. SIGNATURE <b>C.E. McWilliams</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | DEGREE <b>MD</b>                                                                                           |                                                                                      | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED <b>Feb 5, 1969</b>                                                          |  |                                                         |  |
| 22d. PHYSICIAN'S NAME (Type) <b>C.E. McWilliams</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS <b>Reisterstown Maryland</b>                                                                  |                                                                                      |                                                                                                                                                          |  |                                                                                              |  |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE <b>Feb. 6, 1969</b>                                                                              |                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>                                                                                              |  | 23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co., Md.</b>               |  |                                                         |  |
| 24. FUNERAL DIRECTOR <b>H. J. Schhardt</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | ADDRESS <b>Owings Mills, Md.</b>                                                                           |                                                                                      | 25a. REC'D BY REGISTRAR <b>Feb 6 1969</b>                                                                                                                |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>                                              |  |                                                         |  |

|                        |  |                  |  |                    |  |                 |  |                      |  |
|------------------------|--|------------------|--|--------------------|--|-----------------|--|----------------------|--|
| Name                   |  | Address          |  | City               |  | State           |  | Zip                  |  |
|                        |  |                  |  |                    |  |                 |  |                      |  |
| Occupation             |  | Education        |  | Age                |  | Sex             |  | Race                 |  |
|                        |  |                  |  |                    |  |                 |  |                      |  |
| Marital Status         |  | Date of Birth    |  | Date of Marriage   |  | Date of Divorce |  | Date of Death        |  |
|                        |  |                  |  |                    |  |                 |  |                      |  |
| Social Security Number |  | Date of Issuance |  | Date of Expiration |  | Date of Renewal |  | Date of Cancellation |  |
|                        |  |                  |  |                    |  |                 |  |                      |  |
| Signature              |  | Date             |  | Place              |  | Witness         |  | Notary               |  |
|                        |  |                  |  |                    |  |                 |  |                      |  |
| Printed Name           |  | Date             |  | Place              |  | Witness         |  | Notary               |  |
|                        |  |                  |  |                    |  |                 |  |                      |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

02144

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02139

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                                      |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | First Middle Last                                                                                     |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year                                                                                                                                                                                                                                                            |  |  | 2b. HOUR                                                                             |  |  |
| CLARENCE EDWARD SULLIVAN JR.                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |                                                                                                       |  |  | 2. DATE PRONOUNCED DEAD<br>Month Day Year                                                                                                                                                                                                                                                                                             |  |  | 2d. HOUR                                                                             |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 4. RACE<br>White                                                                                      |  |  | 5. DATE OF BIRTH<br>1-25-32                                                                                                                                                                                                                                                                                                           |  |  | 6. AGE (in years last birthday)<br>37 YRS.                                           |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                                              |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                           |  |  | 9. COUNTY OF DEATH<br>Balto.                                                         |  |  |
| 10. CITY OR TOWN OF DEATH<br>Essex                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>1629 Gail Rd. APT. 4B |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Prod. Mach.                                                                                                                                                                                                                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>American Can                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.                                                                                                                                                                                                                                                                                                                                   |  |  | 13b. COUNTY<br>Balto.                                                                                 |  |  | 13c. CITY OR TOWN<br>Essex                                                                                                                                                                                                                                                                                                            |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Clarence E. Sullivan Sr.                                                                                                                                                                                                                                                                                                                                                                     |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Emma Friesen                                         |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes                                                                                                                                                                                                                                                          |  |  | 16b. SOCIAL SECURITY NO.<br>Korean 213-28-3685                                       |  |  |
| 17. INFORMANT<br>Mary F. Sullivan                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | ADDRESS<br>Glen Burnie Md.<br>58 Glen Ridge Rd Apt A 4                                                |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                       |  |  |                                                                                                                                                                                                                                                                                                                                       |  |  |                                                                                      |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                     |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Partial                                                                                                                                                                                                                                           |  |  |                                                                                      |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 2 25 19 69                                  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Self-inflicted gunshot wound                                                                                                                                                                                                                       |  |  |                                                                                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Home                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>1629 Gail Rd. Apt. 4B Essex Balto. Md.                                                                                                                                                                                                                                |  |  |                                                                                      |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | 22b. DATE SIGNED<br>2/26/69                                                                           |  |  | 22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county)                                                                                                                 |  |  |                                                                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 23b. DATE<br>3-1-1969                                                                                 |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                                                                                                                                                                                            |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto City Baltimore Md.            |  |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                                                                                                                                      |  |  | 25a. REC'D BY REGISTRAR<br>MAR 3 1969                                                                 |  |  | 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                            |  |  |                                                                                      |  |  |

02132

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02132

DEATH CERTIFICATE

1

DEATH CERTIFICATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02145</div> <div> <div>1</div> <div>12</div> </div> <div> <div>02140</div> <div>1</div> </div>                                                                                                                                                                                                                                  |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                     |  |  |  |  |  | First                                                                        |  | Middle                                                                                                                                                   |  | Last                                                                 |                                              |
| William                                                                                                                                                                                                                                                                                                                              |  |  |  |  |  | J.                                                                           |  | Sullivan                                                                                                                                                 |  |                                                                      |                                              |
| 3. SEX                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                         |  | 2a. DATE OF DEATH                                                    |                                              |
| Male                                                                                                                                                                                                                                                                                                                                 |  |  |  |  |  | White                                                                        |  | 11-1-1917                                                                                                                                                |  | February 17, 1969                                                    |                                              |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                            |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                   |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  | U.S.A.                                                                       |  |                                                                                                                                                          |  | Baltimore                                                            |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                            |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                              |
| Towson                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  | St. Joseph Hospital                                                          |  | Balto. Gas & Elect. Co.                                                                                                                                  |  | Operator Power Station                                               |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                                                                                                                                                                                                                                              |  |  |  |  |  | 13b. CITY OR TOWN                                                            |  | 13c. INSIDE CITY LIMITS?                                                                                                                                 |  | 13e. STREET AND NUMBER                                               |                                              |
| Maryland                                                                                                                                                                                                                                                                                                                             |  |  |  |  |  | Baltimore                                                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                      |  | 3207 Woodhome Ave. #21234                                            |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                    |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME                                                     |  |                                                                                                                                                          |  |                                                                      |                                              |
| Philip                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  | Eleanor                                                                      |  |                                                                                                                                                          |  |                                                                      |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown                                                                                                                                                                                                                                                                      |  |  |  |  |  | 16b. SOCIAL SECURITY NO. (If give war or dates of service)                   |  | 17. INFORMANT                                                                                                                                            |  | Address                                                              |                                              |
| no                                                                                                                                                                                                                                                                                                                                   |  |  |  |  |  | 215-10-7583                                                                  |  | Anne M. Sullivan                                                                                                                                         |  | same                                                                 |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                            |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction with ventricular fibrillation and shock.</u>                                                                                                                                                                                                         |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                                                                                                                                                                                       |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                   |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                               |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?                                                                                                                                            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                              |
|                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                              |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |  |                                                                      |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                   |  |  |  |  |  | 21b. TIME OF INJURY                                                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  | HOUR A.M. Month Day Year                                                     |  |                                                                                                                                                          |  |                                                                      |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                             |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| 22a. I certify that (1) (this hospital) attended the deceased from February 17, 1969, to February 17, 1969, that (1) (we) last saw the deceased alive on February 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| 22b. SIGNATURE <u>Tomboc</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. DATE SIGNED February 17, 1969                                                                                                                               |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| 22d. PHYSICIAN'S NAME (Type) Camilo Tomboc, M.D. 22e. ADDRESS 7620 York Road, Towson, Md. 21204                                                                                                                                                                                                                                      |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                            |  |  |  |  |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)                        |                                              |
| Burial                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  | 2/20/69                                                                      |  | Parkwood Cem.                                                                                                                                            |  | Balto. Md.                                                           |                                              |
| 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.                                                                                                                                                                                                                                                                         |  |  |  |  |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |                                              |
| 25a. REC'D BY REGISTRAR DATE FEB 19 1969                                                                                                                                                                                                                                                                                             |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                                                   |  |                                                                                                                                                          |  |                                                                      |                                              |

03140

MINISTRE OF HEALTH

03140

SIS-10-723

Info. 101.

Technical Com.

2/20/61

101

General & Tech. Inc. 101.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| <div>02146</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02141</div>                                                                                                                                                                                                                                                                             |  |                                                                                                       |                                                       |                                                                                                                                                                        |                                                  |                                                                                              |  |                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br>ADOLPH J. SWITALSKI                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                       |                                                       |                                                                                                                                                                        | 2a. DATE OF DEATH<br>Month Day Year<br>2 12 1969 |                                                                                              |  | 2b. HOUR<br>10:45 AM                                    |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE<br>White                                                                                      |                                                       | 5. DATE OF BIRTH<br>6-6-01                                                                                                                                             |                                                  | 6. AGE (In years lost birthday)<br>67 YRS.                                                   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Pa                                                                                                                                                                                                                                                                                                                                                                                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A                                                                 |                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                  | 9. COUNTY OF DEATH<br>BALTO Md.                                                              |  |                                                         |  |
| 10. CITY OR TOWN OF DEATH<br>CATONSVILLE                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SPRING GROVE ST. HOSP |                                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>LABORER                                                                     |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Brewery                                                 |  |                                                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD                                                                                                                                                                                                                                                                                                                                     |  | 13b. COUNTY<br>BALTO                                                                                  |                                                       | 13c. CITY OR TOWN<br>BALTO 22                                                                                                                                          |                                                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>7402 School Lane Balto 22     |  |
| 14. FATHER'S NAME First Middle Last<br>JOHN SWITALSKI                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                       | 15. MOTHER'S MAIDEN NAME First Middle Last<br>JOHANNA |                                                                                                                                                                        |                                                  |                                                                                              |  |                                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No                                                                                                                                                                                                                                                                                                                                                                |  | 16b. SOCIAL SECURITY NO.<br>196-01-1355A                                                              |                                                       | 17. INFORMANT Address<br>Chart- Spring Grove State Hospital                                                                                                            |                                                  |                                                                                              |  |                                                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA of Tongue, lymphatics and floor of mouth</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                                                       |                                                       |                                                                                                                                                                        |                                                  |                                                                                              |  |                                                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                   |  |                                                                                                       |                                                       |                                                                                                                                                                        |                                                  |                                                                                              |  |                                                         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                      |                                                       | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                      |                                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                            |                                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                        |                                                  |                                                                                              |  |                                                         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work                                                                                                                                                                                                                                                                                                      |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |                                                       | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                           |                                                  |                                                                                              |  |                                                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> , 19 <u>65</u> , to <u>2/12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                  |  |                                                                                                       |                                                       |                                                                                                                                                                        |                                                  |                                                                                              |  |                                                         |  |
| 22b. SIGNATURE<br>Dennis D. Agallianos M.D.                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                       |                                                       | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                        |                                                  | 22c. DATE SIGNED<br>2/12/69                                                                  |  |                                                         |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DENNIS D. AGALLIANOS MD                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                       |                                                       | 22e. ADDRESS<br>SPRING GROVE ST. HOSP                                                                                                                                  |                                                  |                                                                                              |  |                                                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                  |  | 23b. DATE<br>2/15/69                                                                                  |                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br>Polish St. Mary's Nativity Cath.                                                                                                 |                                                  | 23d. LOCATION (City or Town) (County) (State)<br>Plymouth, Luzerne Co. Pa.                   |  |                                                         |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                       |                                                       | 25a. REC'D BY REGISTRAR<br>FEB 17 1969                                                                                                                                 |                                                  | 25b. REGISTRAR'S SIGNATURE<br>Richard J. Jordan                                              |  |                                                         |  |

03141

03141

Handwritten notes and stamps, including "FBI" and "RECEIVED".



1

2

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-60)  
30M REV. 1-60

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                  |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                   |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                   | 2a. DATE OF DEATH                                                                       |                                                                                                                                 | 2b. HOUR                          |                                              |  |
| Arthur                                                                                                                                                                                                                                                                                                |  |                                                                              | S. Taylor                                                                    |                                                                                                                                                          |                                                                                   | February 11 1969                                                                        |                                                                                                                                 | M                                 |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                   | 6. AGE (In years lost birthday)                                                         |                                                                                                                                 | IF UNDER 1 YEAR                   |                                              |  |
| M                                                                                                                                                                                                                                                                                                     |  | W                                                                            |                                                                              | April 23, 1899                                                                                                                                           |                                                                                   | 69 YRS.                                                                                 |                                                                                                                                 | MONTHS DAYS HOURS MIN.            |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                      |                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| Maryland                                                                                                                                                                                                                                                                                              |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                          |                                                                                   | Baltimore                                                                               |                                                                                                                                 | Md.                               |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                             |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                                                                 |                                   |                                              |  |
| Arbutus                                                                                                                                                                                                                                                                                               |  |                                                                              | 5206 Carroll Place                                                           |                                                                                                                                                          |                                                                                   | City Policeman                                                                          |                                                                                                                                 |                                   |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                         |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                                 |                                                                                         | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |                                   | 13e. STREET AND NUMBER                       |  |
| 5206 Carroll Pl.                                                                                                                                                                                                                                                                                      |  |                                                                              | Baltimore                                                                    |                                                                                                                                                          | Arbutus                                                                           |                                                                                         | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             |                                   | 5206 Carroll Place 21227                     |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                     |  |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| First Middle Last                                                                                                                                                                                                                                                                                     |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| Samuel Louis Taylor                                                                                                                                                                                                                                                                                   |  |                                                                              | Ella Virginia Bevans                                                         |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)                                                                                                                                                                                              |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT Address                                                             |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| Yes W W II                                                                                                                                                                                                                                                                                            |  |                                                                              | 215-28-2144                                                                  |                                                                                                                                                          | Mrs. Helmy M. Taylor, 5206 Carroll Place                                          |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   | 2 mo.                                        |  |
| DUE TO, OR AS A CONSEQUENCE OF AS. CVD                                                                                                                                                                                                                                                                |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   | ?                                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                    |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| Coronary Artery Disease                                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                            |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                    |  | 21b. TIME OF INJURY                                                          |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  | HOUR A.M. Month Day Year                                                     |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 1968, to Feb. 11, 1969, that (I) last saw the deceased alive on 2-10-1969, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                              |                                                                                                                                                          | DEGREE                                                                            |                                                                                         | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED                             |  |
| Earl I. Pass                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                   |                                                                                         |                                                                                                                                 |                                   | 2-11-69                                      |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          | 22e. ADDRESS                                                                      |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| Earl I. Pass                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          | 4001 Wilkens Avenue                                                               |                                                                                         |                                                                                                                                 |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                   | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                                                                                 |                                   |                                              |  |
| BURIAL                                                                                                                                                                                                                                                                                                |  | 2-14-1969                                                                    |                                                                              | Baltimore National Cem.                                                                                                                                  |                                                                                   | Baltimore, Maryland                                                                     |                                                                                                                                 |                                   |                                              |  |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              |                                                                                                                                                          | 25a. REC'D BY REGISTRAR                                                           |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                                                                                      |                                   |                                              |  |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229                                                                                                                                                                                                                                                            |  |                                                                              |                                                                              |                                                                                                                                                          | DATE FEB 13 1969                                                                  |                                                                                         | J. Charles Judge                                                                                                                |                                   |                                              |  |

05148

WINDY TO WINDY

05148

TO WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY

WINDY



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02148

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02143

|                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                             |                                                                |                                                                                                                                                                                                                  |                                     |                                                                                              |                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>PEARL E. SMITH TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                                             | 2a. DATE KNOWN OF DEATH ESTI-<br>MATED <b>February 26 1969</b> |                                                                                                                                                                                                                  |                                     | 2b. HOUR <b>11 A</b>                                                                         |                                                                               |  |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                     | 4. RACE<br><b>N</b> | 5. DATE OF BIRTH<br><b>11/16/17</b>                                                                         | 6. AGE (In years lost birthday)<br><b>52 YRS.</b>              | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>                                                                                                                                                                            | IF UNDER 24 HRS<br>DAYS<br><b>0</b> | 2c. DATE PRONOUNCED DEAD<br><b>February 26 1969</b>                                          | 2d. HOUR<br><b>11 A</b>                                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                 |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                               |                                                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                      |                                     | 9. COUNTY OF DEATH<br><b>Balto.</b>                                                          |                                                                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>GOVANS</b>                                                                                                                                                                                                                                                                                                                                                                                             |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>437 1/2 Schwartz Ave</b> |                                                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>domestic</b>                                                                                                       |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Print Home</b>                                       |                                                                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>                                                                                                                                                                                                                                                                                                                                |                     | 13b. COUNTY<br><b>Balto</b>                                                                                 |                                                                | 13c. CITY OR TOWN<br><b>Govans</b>                                                                                                                                                                               |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                               |  |
| 14. FATHER'S NAME<br><b>Jerome</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 15. MOTHER'S MAIDEN NAME<br><b>Rosa</b>                                                                     |                                                                | 13e. STREET AND NUMBER<br><b>437 1/2 Schwartz Ave</b>                                                                                                                                                            |                                     |                                                                                              |                                                                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>                                                                                                                                                                                                                                                                                                                                                        |                     | 16b. SOCIAL SECURITY NO.<br><b>517-28-9667</b>                                                              |                                                                | 17. INFORMANT<br><b>Wm. Taylor</b>                                                                                                                                                                               |                                     | ADDRESS<br><b>437 1/2 Schwartz Ave</b>                                                       |                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>4122<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertensive Cardio-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal Vascular Disease</b>                                                                                                                        |                     |                                                                                                             |                                                                |                                                                                                                                                                                                                  |                                     |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b><br><b>2+ yrs</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |                     |                                                                                                             |                                                                |                                                                                                                                                                                                                  |                                     |                                                                                              |                                                                               |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                           |                                                                |                                                                                                                                                                                                                  |                                     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                                                                               |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b><br>P.M.                                         |                                                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                                  |                                     |                                                                                              |                                                                               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                              |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |                                                                | 21f. LOCATION Street or R.F.D. No.                                                                                                                                                                               |                                     | City or Town County State                                                                    |                                                                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                     |                                                                                                             |                                                                |                                                                                                                                                                                                                  |                                     |                                                                                              |                                                                               |  |
| ACTUAL SIGNATURE<br><b>Charles T. O'Donnell</b>                                                                                                                                                                                                                                                                                                                                                                                        |                     | EXAMINER'S NAME (Type)                                                                                      |                                                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county) |                                     | 22b. DATE SIGNED<br><b>2/26/69</b>                                                           |                                                                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |                     | 23b. DATE<br><b>3/1/69</b>                                                                                  |                                                                | 23c. NAME OF SEMETERY OR CREMATORY<br><b>Resurrection</b>                                                                                                                                                        |                                     | 23d. LOCATION (City or Town) (County) (State)<br><b>Towson, Balto., Co. Md.</b>              |                                                                               |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Chaturian, Jr. 1701 Mt. Airy St. Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                                             |                                                                | 25a. RECEIVED BY REGISTRAR<br><b>FEB 27 1969</b>                                                                                                                                                                 |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Judge</b>                                          |                                                                               |  |

84180

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK  
JANUARY 1, 1911

STATE OF NEW YORK  
JANUARY 1, 1911



OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

JANUARY 1, 1911

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

JANUARY 1, 1911

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

JANUARY 1, 1911

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

JANUARY 1, 1911

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

JANUARY 1, 1911

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK

JANUARY 1, 1911

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 7a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02149

02144

|                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                             |                                                                                                         |                                                                                                                                                             |                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>FRANKLIN THOMAS</b>                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                             | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 2 13 1969 3 A M              |                                                                                                                                                             |                                                                                                                |
| 3. SEX<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>9/22/60</b>                                                          | 6. AGE (In years last birthday)<br><b>68 YRS</b>                                                        | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                                                                                                           | IF UNDER 24 HRS<br>HOURS<br>MIN.                                                                               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                          |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                  |                                                                                                         | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>ESSEX</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                             | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1700 FRENCHS AVE</b> |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>CONSTRUCTION</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>M.D.</b>                                                                                                                                                                                                                                                                                                                                         |                     | 13b. COUNTY <b>BALTO.</b>                                                                   | 13c. CITY OR TOWN<br><b>ESSEX</b>                                                                       | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                             | 13e. STREET AND NUMBER<br><b>1700 FRENCHS AVE</b>                                                              |
| 14. FATHER'S NAME First Middle Last<br><b>JOHN THOMAS</b>                                                                                                                                                                                                                                                                                                                                                                                         |                     |                                                                                             | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>?</b>                                                  |                                                                                                                                                             |                                                                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>UNK</b>                                                                                                                                                                                                                                                                                                                                                                  |                     | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) <b>214-22-9697</b>        |                                                                                                         | 17. INFORMANT ADDRESS<br><b>MILDRED THOMAS ABOVE</b>                                                                                                        |                                                                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gun shot wound self inflicted</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                                                           |                     |                                                                                             |                                                                                                         |                                                                                                                                                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Emphysema Mental Depression</b>                                                                                                                                                                                                                                                                 |                     |                                                                                             |                                                                                                         |                                                                                                                                                             |                                                                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                           |                                                                                                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                         |                                                                                                                |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                       |                     | 21b. TIME OF INJURY Month, Day, Year<br><b>3 27/3/69</b>                                    |                                                                                                         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>See above</b>                                                         |                                                                                                                |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK                                                                                                                                                                                                                                                                                                                                 |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b> |                                                                                                         | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>1700 French Ave. Balto Md</b>                                                            |                                                                                                                |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                     |                                                                                             |                                                                                                         |                                                                                                                                                             |                                                                                                                |
| ACTUAL SIGNATURE<br><b>Theo C. Patterson</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                     | M.D.<br><b>THEO C. PATTERSON</b>                                                            |                                                                                                         | 22b. DATE SIGNED<br><b>2/13/69</b>                                                                                                                          |                                                                                                                |
| EXAMINER'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | ADDRESS                                                                                     |                                                                                                         |                                                                                                                                                             |                                                                                                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                        |                     | 23b. DATE<br><b>2/15/69</b>                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                                                |                                                                                                                                                             | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                                             |
| 24. FUNERAL DIRECTOR<br><b>J.E. CONNELLY SONS</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                             | 25a. REC'D BY REGISTRAR<br><b>FEB 17 1969</b>                                                           |                                                                                                                                                             | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                               |

0518

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| <div style="display: flex; justify-content: space-between;"> <span>02150</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02145</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>                                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------|------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              | First Middle Last                                                            |                                                                                                                                                             |                                                                                   | 2a. DATE OF DEATH                                                                                                               |                                                                                   | 7b. HOUR                          |                        |  |
| Maggie                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | L. Thomas                                                                    |                                                                                                                                                             |                                                                                   | February 20, 1969                                                                                                               |                                                                                   | 12:10 p. M.                       |                        |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                            |                                                                                   | 6. AGE (In years last birthday)                                                                                                 |                                                                                   | IF UNDER 1 YEAR MONTHS DAYS       |                        |  |
| female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Negro                                                                        |                                                                              | Aug. 28, 1917                                                                                                                                               |                                                                                   | 54 YRS.                                                                                                                         |                                                                                   | IF UNDER 24 HRS. HOURS MIN        |                        |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                   | 9. COUNTY OF DEATH                                                                                                              |                                                                                   | Md.                               |                        |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | U. S.                                                                        |                                                                              |                                                                                                                                                             |                                                                                   | Baltimore                                                                                                                       |                                                                                   |                                   |                        |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                             |                                                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                         |                                                                                   | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                              | SPRING GROVE STATE HOSP.                                                     |                                                                                                                                                             |                                                                                   | housewife                                                                                                                       |                                                                                   |                                   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN                                                                 |                                                                                                                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              |                                                                                                                                                             | Balto.                                                                            |                                                                                                                                 | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 624 West Barre Street  |  |
| 14. FATHER'S NAME First Middle Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |                                                                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                                                                                                  |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| James Lawrence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |                                                                              | Lorena Goodman                                                                                                                                              |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                             | 17. INFORMANT Address                                                             |                                                                                                                                 |                                                                                   |                                   |                        |  |
| (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              | 214-24-2547                                                                  |                                                                                                                                                             | Records: SPRING GROVE STATE HOSPITAL                                              |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary embolism, suspected</u><br><u>453X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Deep Pelvic vein thrombosis, suspected</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min.</u><br><u>3 days</u> |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>undetermined.</u><br>(1) <u>Alcoholism, chronic,</u> (2) <u>Malnutrition, 2 to (1),</u> (3) <u>Anemia, cause</u>                                                                                                                                                                                                                                                   |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                             | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                                   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 3</u> , 1969, to <u>Feb. 20</u> , 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 20</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                             |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 22b. SIGNATURE <u>Anthony J. Young, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                              | DEGREE                                                                                                                                                      |                                                                                   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                                                                   | 22c. DATE SIGNED <u>2-20-69</u>   |                        |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                              | 22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u><br><u>Baltimore, Maryland 21228</u>                                                                         |                                                                                   |                                                                                                                                 |                                                                                   |                                   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                                                                   | 23d. LOCATION (City or Town) (County) (State)                                                                                   |                                                                                   |                                   |                        |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 2-25-69                                                                      |                                                                              | Mt. Calvary                                                                                                                                                 |                                                                                   | Brooklyn, Maryland                                                                                                              |                                                                                   |                                   |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                              | 25a. REC'D BY REGISTRAR                                                                                                                                     |                                                                                   | 25b. REGISTRAR'S SIGNATURE                                                                                                      |                                                                                   |                                   |                        |  |
| Charles A. Rice 661 W. Barre St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                              | DATE <u>FEB 24 1969</u>                                                                                                                                     |                                                                                   | <u>Charles Judge</u>                                                                                                            |                                                                                   |                                   |                        |  |



02115

COMMUNICATIONS SECTION

02115

TO: [illegible] FROM: [illegible] SUBJECT: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

02115

02115



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | First<br><b>Helen</b>                                                                                              |  | Middle<br><b>Todd</b>                                                                                                                                       |                                                                                                             | Last<br><b>Todd</b>                                 |                                                                      | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>17</b> Year <b>1969</b> |                                              |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 4. RACE<br><b>White</b>                                                                                            |  | 5. DATE OF BIRTH<br><b>3/26/77</b>                                                                                                                          |                                                                                                             | 6. AGE (In years last birthday)<br><b>91</b> YRS.   |                                                                      | 2b. HOUR<br><b>12:45</b> MIN.                                             |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>American</b>                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                             | 9. COUNTY OF DEATH<br><b>Baltimore</b>              |                                                                      | Md.                                                                       |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SPRING GROVE STATE HOSPITAL</b> |  |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |                                                     |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                         |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                               |  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>                                                                              |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                      |                                                                                                             | 13e. STREET AND NUMBER<br><b>2038 Linden Avenue</b> |                                                                      |                                                                           |                                              |  |
| 14. FATHER'S NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |  | 15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>                            |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-54-3450J1</b>                                                                   |  | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>                                                                                        |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4124</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                     |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Parkinson's Disease</b>                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                   |  |                                                                                                                                                             | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>          |                                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                                           |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                            |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                  |  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |                                                     |                                                                      |                                                                           |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                        |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                |                                                     |                                                                      |                                                                           |                                              |  |
| 22a. I certify that <b>Dr. Diomidis Pirovolidis</b> (this hospital) attended the deceased from <b>Jan. 14</b> , 19 <b>54</b> , to <b>Feb. 17</b> , 19 <b>69</b> , that (I) <b>Dr. Diomidis Pirovolidis</b> saw the deceased alive on <b>Feb. 17</b> , 19 <b>69</b> , and that in (my) <b>Dr. Diomidis Pirovolidis</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>Dr. Diomidis Pirovolidis</b> (did) <b>not</b> view the body after death. |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| 22b. SIGNATURE<br><b>Diomidis L. Pirovolidis, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | 22c. DATE SIGNED<br><b>2-17-69</b>                                                                                 |  |                                                                                                                                                             | 22d. PHYSICIAN'S NAME (Type)<br><b>Diomidis Pirovolidis, M.D.</b>                                           |                                                     |                                                                      |                                                                           |                                              |  |
| 22e. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                    |  |                                                                                                                                                             |                                                                                                             |                                                     |                                                                      |                                                                           |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>2-21-69</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 23b. DATE<br><b>2-21-69</b>                                                                                        |  |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cem.</b>                                                |                                                     |                                                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>     |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Tucker &amp; Sons</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | ADDRESS<br><b>Baltimore, Md.</b>                                                                                   |  |                                                                                                                                                             | 25a. RECEIVED BY REGISTRAR<br><b>FEB 24 1969</b>                                                            |                                                     |                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>William H. Linder</b>                    |                                              |  |

MEDICAL CERTIFICATION

相対

232

59034

19

970131

425 55

CERTIFICATE OF DEATH

02147

02152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                                                                                |         |                                                                                 |                  |                                                                                                                                                             |                                     |                                                                                                 |                                |                                                                                             |      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------|------|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                            |         | First                                                                           | Middle           | Last                                                                                                                                                        | 2a. DATE OF DEATH<br>Month Day Year |                                                                                                 | 2b. HOUR<br>M.                 |                                                                                             |      |
| Michael Tomko                                                                                                                                                                                                                                                                                                                                                                                                                  |         |                                                                                 |                  |                                                                                                                                                             | February 3, 1969                    |                                                                                                 | 6:30 P.                        |                                                                                             |      |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE |                                                                                 | 5. DATE OF BIRTH |                                                                                                                                                             | 6. AGE (In years<br>last birthday)  |                                                                                                 | IF UNDER 1 YEAR<br>MONTHS DAYS |                                                                                             |      |
| M                                                                                                                                                                                                                                                                                                                                                                                                                              | W       |                                                                                 | 2/6/1909         |                                                                                                                                                             | 59 YRS.                             |                                                                                                 |                                |                                                                                             |      |
| 7a. BIRTHPLACE (State or foreign<br>country)                                                                                                                                                                                                                                                                                                                                                                                   |         | 7b. CITIZEN OF WHAT COUNTRY?                                                    |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH                                                                              |                                |                                                                                             |      |
| Czechoslovakia                                                                                                                                                                                                                                                                                                                                                                                                                 |         | U.S.A.                                                                          |                  |                                                                                                                                                             |                                     | Baltimore Md.                                                                                   |                                |                                                                                             |      |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                      |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                                                                  |                                     | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |                                |                                                                                             |      |
| Balto. 12                                                                                                                                                                                                                                                                                                                                                                                                                      |         | 1409 Glendale Road                                                              |                  | Engineer                                                                                                                                                    |                                     | Gas & Elec. Co.                                                                                 |                                |                                                                                             |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE                                                                                                                                                                                                                                                                                                                               |         | 13b. COUNTY                                                                     |                  | 13c. CITY OR TOWN                                                                                                                                           |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER                                                                      |      |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                            |         | Balto.                                                                          |                  | Balto. 12                                                                                                                                                   |                                     | YES                                                                                             |                                | 1409 Glendale Road                                                                          |      |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                              |         | First                                                                           | Middle           | Last                                                                                                                                                        | 15. MOTHER'S MAIDEN NAME            |                                                                                                 | First                          | Middle                                                                                      | Last |
| Paul Tomko                                                                                                                                                                                                                                                                                                                                                                                                                     |         |                                                                                 |                  |                                                                                                                                                             | Mary Maty                           |                                                                                                 |                                |                                                                                             |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                                     |         | 16b. SOCIAL SECURITY NO.                                                        |                  | 17. INFORMANT                                                                                                                                               |                                     | Address                                                                                         |                                |                                                                                             |      |
| No                                                                                                                                                                                                                                                                                                                                                                                                                             |         | 194-01-5681                                                                     |                  | Mrs. Agnes M. Tomko                                                                                                                                         |                                     | (Same)                                                                                          |                                |                                                                                             |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute coronary occl/45 ion</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>915</u> |         |                                                                                 |                  |                                                                                                                                                             |                                     |                                                                                                 |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>MINUTES</u>                           |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                            |         |                                                                                 |                  |                                                                                                                                                             |                                     |                                                                                                 |                                |                                                                                             |      |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                         |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                                |                                                                                             |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                       |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                     |                                                                                                 |                                |                                                                                             |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                     | City or Town                                                                                    |                                | County State                                                                                |      |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>JAN 12, 1969</u> to <u>FEB. 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>JAN. 12, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                    |         |                                                                                 |                  |                                                                                                                                                             |                                     |                                                                                                 |                                |                                                                                             |      |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                 |         | 22c. DATE SIGNED                                                                |                  | 22d. PHYSICIAN'S NAME (Type)                                                                                                                                |                                     | 22e. ADDRESS                                                                                    |                                | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |      |
| <u>Dr. S. J. Venable, Jr.</u>                                                                                                                                                                                                                                                                                                                                                                                                  |         | <u>FEB. 4, 1969</u>                                                             |                  | <u>Dr. S. J. Venable, Jr.</u>                                                                                                                               |                                     | <u>7215 York Road</u>                                                                           |                                | <u>21212</u>                                                                                |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                   |         | 23b. DATE                                                                       |                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                          |                                     | 23d. LOCATION (City or Town) (County) (State)                                                   |                                |                                                                                             |      |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                         |         | 2/6/1969                                                                        |                  | Loudon Park                                                                                                                                                 |                                     | Baltimore Md.                                                                                   |                                |                                                                                             |      |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                           |         | ADDRESS                                                                         |                  | 25a. REC'D BY REGISTRAR                                                                                                                                     |                                     | 25b. REGISTRAR'S SIGNATURE                                                                      |                                |                                                                                             |      |
| H. W. Jenkins & Sons Co.                                                                                                                                                                                                                                                                                                                                                                                                       |         | 4905 York Road<br>Balto. 12, Md.                                                |                  | DATE FEB 4 1969                                                                                                                                             |                                     | <u>Charles Judge</u>                                                                            |                                |                                                                                             |      |

02187

CONFIDENTIAL

02187

Administrative Conference  
Haut Secondary School for  
Mentals

Jan 12 1963

Handwritten signature/initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                |  |                                                                                                                                                             |  |                                                                                      |  |                                                                         |  |                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|----------------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                |  |                                                                                                                                                             |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                   |  | First <u>Wong</u>                                                                                              |  | Middle <u>Yee</u>                                                                                                                                           |  | Last <u>Toon</u>                                                                     |  | 2a. DATE OF DEATH<br>Month <u>2</u> Day <u>11</u> Year <u>69</u>        |  | 2b. HOUR<br><u>12</u> <sup>10</sup> <sub>PM</sub>  |  |
| 3. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 4. RACE<br><u>CHINESE</u>                                                                                      |  | 5. DATE OF BIRTH<br><u>8/13/96</u>                                                                                                                          |  | 6. AGE (In years<br>last birthday)<br><u>72</u> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u>                      |  | IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN. <u>  </u> |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><u>CHINA</u>                                                                                                                                                                                                                                                                                                                                                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>✓</u>                                                                       |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Baltimore County,</u> Md.                                   |  |                                                                         |  |                                                    |  |
| 10. CITY OR TOWN OF DEATH<br><u>Mount Wilson</u>                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><u>Mt. Wilson St. Hosp.</u> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><u>LAUNDRY WORKER</u>                                         |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><u>Laundry</u>                               |  |                                                                         |  |                                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived,<br>admission) STATE<br><u>MARYLAND</u>                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY<br><u>  </u>                                                                                       |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>                                                                                                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>210 W. PLEASANT ST.</u>                    |  |                                                    |  |
| 14. FATHER'S NAME First<br><u>UNKNOWN</u>                                                                                                                                                                                                                                                                                                                                                                             |  | Middle<br><u>  </u>                                                                                            |  | Last<br><u>  </u>                                                                                                                                           |  | 15. MOTHER'S MAIDEN NAME First<br><u>UNKNOWN</u>                                     |  | Middle<br><u>  </u>                                                     |  | Last<br><u>  </u>                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><u>216-32-9289</u>                                                                 |  | 17. INFORMANT Address<br><u>Records, Mt. Wilson State Hospital</u>                                                                                          |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>FAR ADVANCED PULMONARY TUBERCULOSIS</u><br><u>011.2</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <u>  </u><br>(b) <u>  </u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>  </u> |  |                                                                                                                |  |                                                                                                                                                             |  |                                                                                      |  |                                                                         |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                    |  |                                                                                                                |  |                                                                                                                                                             |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                               |  |                                                                                                                                                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u><br>P.M. <u>  </u>      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>                                                        |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/7</u> , 19 <u>69</u> , to <u>2/11</u> , 19 <u>69</u> , that (I) (we) last<br>saw the deceased alive on <u>2/11</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                               |  |                                                                                                                |  |                                                                                                                                                             |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 22b. SIGNATURE<br><u>W Newcomer</u>                                                                                                                                                                                                                                                                                                                                                                                   |  | DEGREE<br><u>  </u>                                                                                            |  | ATTENDING<br>PHYS. <input type="checkbox"/>                                                                                                                 |  | MED.<br>DIRECTOR <input checked="" type="checkbox"/>                                 |  | STAFF<br>PHYS. <input type="checkbox"/>                                 |  | 22c. DATE SIGNED                                   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><u>William Newcomer, M.D.</u>                                                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS<br><u>Mount Wilson, Maryland</u>                                                                  |  |                                                                                                                                                             |  |                                                                                      |  |                                                                         |  |                                                    |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><u>Feb. 15, 1969</u>                                                                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>LORRAINE PARK CEM.</u>                                                                                             |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Woodlawn, Balto. Co., Md.</u>    |  |                                                                         |  |                                                    |  |
| 24. FUNERAL DIRECTOR<br><u>STEWART &amp; MOWEN CO.</u>                                                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><u>108 W. North Av., City 1</u>                                                                     |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 17 1969</u>                                                                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard J. Jones</u>                                |  |                                                                         |  |                                                    |  |

02148

02148

Lincoln County,

China

Mount Wilson

Mr. Wilson, N. H.

Lincoln County, N. H.

Mount Wilson, N. H.

Mr. Wilson, N. H.

Feb. 1, 1902



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02154

02149

|                                                                                                                                                                                                                                                                                                                             |                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                 |                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Jonathan Wayne Townsend                                                                                                                                                                                                                                            |                                                                                                            |                                                                                                                                                             | 2a. DATE OF DEATH<br>2 Month 13 Day 69 Year                                                     |                                                                                 | 2b. HOUR<br>1:30 M                           |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                              | 4. RACE<br>Caucasian                                                                                       | 5. DATE OF BIRTH<br>2/2/69                                                                                                                                  |                                                                                                 | 6. AGE (In years last birthday)<br>YRS. MONTHS DAYS<br>11                       | IF UNDER 1 YEAR<br>HOURS MIN.                |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.                                                                                                                                                                                                                                                                            | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Baltimore Md.                                                             |                                                                                 |                                              |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         | 12b. KIND OF BUSINESS OR INDUSTRY                                               |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br>Md.                                                                                                                                                                                                                        | 13b. COUNTY<br>Baltimore                                                                                   | 13c. CITY OR TOWN<br>Freeland                                                                                                                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br>Freeland Rd.                                          |                                              |
| 14. FATHER'S NAME First Middle Last<br>Edward W. Townsend                                                                                                                                                                                                                                                                   |                                                                                                            | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Marguerite McGolrick                                                                                          |                                                                                                 |                                                                                 |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown (If yes give war or dates of service)                                                                                                                                                                                                                   |                                                                                                            | 16b. SOCIAL SECURITY NO.                                                                                                                                    | 17. INFORMANT Address<br>Edw. W. Townsend, Freeland Md.                                         |                                                                                 |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                          |                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                 |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                      |                                                                                                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                              |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                    |                                                                                                            | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                              |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                |                                                                                                            | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |                                                                                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11, 1969, to 2/13, 1969, that (I) (we) last saw the deceased alive on 2/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |                                                                                                            |                                                                                                                                                             |                                                                                                 |                                                                                 |                                              |
| 22b. SIGNATURE<br>Charles C. Brown, M.D.                                                                                                                                                                                                                                                                                    |                                                                                                            |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED<br>2/13/69                                                     |                                              |
| 22d. PHYSICIAN'S NAME (Type)<br>Charles C. Brown, M.D.                                                                                                                                                                                                                                                                      |                                                                                                            |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br>6701 North Charles Street                                       |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                   |                                                                                                            | 23b. DATE<br>Febr. 15, 1969                                                                                                                                 |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Zion Cemetery                         |                                              |
| 24. FUNERAL DIRECTOR<br>James Wartenstein                                                                                                                                                                                                                                                                                   |                                                                                                            | 25a. REC'D BY REGISTRAR<br>DATE<br>FEB 19 1969                                                                                                              |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br>James Wartenstein                                 |                                              |



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                            |  |                         |                                                                                                          |                                                                                                                          |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                |  |                         |                                                                                                          |                                                                                                                          |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                    |  |                         | First<br><b>BETTY</b>                                                                                    |                                                                                                                          | Middle<br><b>JANE</b> |                                                                                                                                                             | Last<br><b>TRAEGER</b> |                                                                                                                          |                                                                                                 | 2a. DATE KNOWN OF DEATH<br>Month <input checked="" type="checkbox"/> Year <b>1969</b> |                                                         | 2b. HOUR<br><b>5:35</b> PM                                                          |  |                                                                   |  |                                                                       |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE<br><b>White</b> |                                                                                                          | 5. DATE OF BIRTH<br><b>Dec. 10, 1928</b>                                                                                 |                       | 6. AGE (In years last birthday)<br><b>40</b> YRS.                                                                                                           |                        | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____                                                                               |                                                                                                 | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                                            |                                                         | 2c. DATE PRONOUNCED DEAD<br>Month <b>February</b> Day <b>5</b> Year <b>19 69</b>    |  | 2d. HOUR<br><b>5:35</b> P M                                       |  |                                                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                                                             |                                                                                                                          |                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        |                                                                                                                          | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                                      |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>G.B.M.C. Hospital</b> |                                                                                                                          |                       |                                                                                                                                                             |                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Insurance Manager</b>      |                                                                                                 |                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b> |                                                                                     |  |                                                                   |  |                                                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                            |  |                         | 13b. CITY OR TOWN<br><b>Anne Arundel</b>                                                                 |                                                                                                                          |                       | 13c. CITY OR TOWN<br><b>Glen Burnie</b>                                                                                                                     |                        |                                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                       |                                                         | 13e. STREET AND NUMBER<br><b>Route #1 Box 265 Lombardee Rd.</b>                     |  |                                                                   |  |                                                                       |  |
| 14. FATHER'S NAME<br>First <b>William</b> Middle <b>Craft</b> Last <b>Westhoff</b>                                                                                                                                                                                                                                                                                                                                                     |  |                         | 15. MOTHER'S MAIDEN NAME<br>First <b>Nellie</b> Middle <b>---</b> Last <b>Skelly</b>                     |                                                                                                                          |                       | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         |                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) |  | 17. INFORMANT<br><b>Raymond Traeger-Rt.1, Pox265, Lombardie Beach</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-cranial injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                                                          |  |                         |                                                                                                          |                                                                                                                          |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                        |  |                                                                   |  |                                                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                     |  |                         |                                                                                                          |                                                                                                                          |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                         |                                                                                                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                        |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                                                   |  |                                                                       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                         |  |                         |                                                                                                          | 21b. TIME OF INJURY Month, Day, Year<br><b>4:05 P.M. 5-2 19 69</b>                                                       |                       |                                                                                                                                                             |                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Driver in auto-truck collision</b> |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  |                         |                                                                                                          | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Expressway #695 east of Falls Rd.</b> |                       |                                                                                                                                                             |                        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Baltimore Md.</b>                                     |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> |  |                         |                                                                                                          |                                                                                                                          |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                         |                                                                                                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                          |                       |                                                                                                                                                             |                        | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                           |                                                                                                 |                                                                                       |                                                         | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                    |  | 22b. DATE SIGNED<br><b>February 6, 1969</b>                       |  |                                                                       |  |
| EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                         |                                                                                                          | ADDRESS (Street, city, town, or county)                                                                                  |                       |                                                                                                                                                             |                        |                                                                                                                          |                                                                                                 |                                                                                       |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                         |                                                                                                          | 23b. DATE<br><b>2-10-1969</b>                                                                                            |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Memorial Pk. Glen Burnie, A. A. Co., Md.</b>                                                            |                        |                                                                                                                          |                                                                                                 | 23d. LOCATION (City or Town) (County) (State)                                         |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonce-4001 Ritchie Hgwy., Baltimore</b>                                                                                                                                                                                                                                                                                                                                                           |  |                         |                                                                                                          |                                                                                                                          |                       | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1969</b>                                                                                                               |                        |                                                                                                                          |                                                                                                 | 25b. REGISTRAR'S SIGNATURE                                                            |                                                         |                                                                                     |  |                                                                   |  |                                                                       |  |

03150

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

03155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b<br><b>Catonsville</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1038 Lakemont Road</b>                                                                                                                                                                                                                                                            |                                                                                                                                                                | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Md</b><br>b. COUNTY <b>Balto</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>d. STREET ADDRESS <b>1038 Lakemont Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                           |
| 3. NAME OF DECEASED<br>(Type or print) <b>Emma Triplet</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>1</b> Year <b>1969</b>                                                                                                                                                                                                                                                                                                                              |                                                                           |
| 5. SEX <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 6. COLOR OR RACE <b>White</b>                                                                                                                                  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                   | 8. DATE OF BIRTH <b>5/15/90</b>                                           |
| 9. AGE (In years last birthday) <b>78</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>                                                                                                                                                                                                                                                                                   | 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b> |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                | 13. FATHER'S NAME <b>John Wesley Arther</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                           |
| 14. MOTHER'S MAIDEN NAME <b>Martha McDonell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>                                                                                                                                                                                                                                                                                                |                                                                           |
| 16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                | 17. INFORMANT <b>Mr. Wm. H. Triplet</b> , Address <b>1038 Lakemont Road</b>                                                                                                                                                                                                                                                                                                                   |                                                                           |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute heart failure. Arteriosclerotic</b><br>(b) <b>Degenerative C.V.D. Coronary Insufficiency</b><br>(c) <b>and sclerotic. Auricular Fibrillation.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                           |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                                                                                                                                                                                                                                                                  |                                                                           |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                                                                                                                                                                                                                                                                                                        | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1969 to 1 Feb.</b> , that (I) (we) last saw the deceased alive on <b>1 Feb.</b> , and that death occurred at <b>8:25 PM</b> from the causes and on the date stated above.                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                           |
| 22a. SIGNATURE <b>Joseph E. Muse Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                | 22b. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                              |                                                                           |
| 22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Muse, Jr. M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                | 22d. ADDRESS <b>2725 N. Charles St.</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 23b. DATE THEREOF <b>2/5/69</b>                                                                                                                                | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>                                                                                                                                                                                                                                                                                                                                | 23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>        |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke, 4101 Edmondson Ave., 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                | 25a. REC'D BY REGISTRAR <b>CCB</b> 25b. REGISTRAR'S SIGNATURE <b>5 1969</b>                                                                                                                                                                                                                                                                                                                   |                                                                           |

08121

08121

STATE OF TEXAS

IN SENATE,  
January 1, 1911.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1910.  
BY  
J. W. HARRIS,  
COMMISSIONER.  
DALLAS: THE TEXAS BOOK CONCERN, 1911.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 02157                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                     |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                              |  |                                                                                              |  | 02152                                           |  |                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|-----------------------------|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                     |  | 2a. DATE OF DEATH                                                                                                                                        |  |                                                                                              |  | 2b. HOUR                                        |  |                             |  |
| First John Middle Wilson Last Turner                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  | 2 Month 12 Day 1969                                                                                                                                      |  |                                                                                              |  | 11:45 A.M.                                      |  |                             |  |
| 3. SEX M                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 4. RACE W                                                                                           |  | 5. DATE OF BIRTH 1-14-1910                                                                                                                               |  | 6. AGE (In years last birthday) 59 YRS.                                                      |  | IF UNDER 1 YEAR MONTHS DAYS                     |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) Maryland                                                                                                                                                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.                                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH Baltimore Md.                                                             |  |                                                 |  |                             |  |
| 10. CITY OR TOWN OF DEATH Towson                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Gr. Balto. Med. Center |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Superintendent                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY Contracting                                                |  |                                                 |  |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland                                                                                                                                                                                                                                                                                                                                                          |  | 13b. COUNTY Baltimore                                                                               |  | 13c. CITY OR TOWN Towson                                                                                                                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER 929 Fairmount Avenue     |  |                             |  |
| 14. FATHER'S NAME First Charles Middle Turner Last                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                     |  | 15. MOTHER'S MAIDEN NAME First Laura Middle Fairbanks Last                                                                                               |  |                                                                                              |  |                                                 |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                          |  |                                                                                                     |  | 16b. SOCIAL SECURITY NO. 216-05-7090                                                                                                                     |  | 17. INFORMANT Address Mrs. Jeanne C. Turner 929 Fairmount Av                                 |  |                                                 |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.<br>9 yrs. |  |                                                                                                     |  |                                                                                                                                                          |  |                                                                                              |  |                                                 |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                              |  |                                                                                                     |  |                                                                                                                                                          |  |                                                                                              |  |                                                 |  |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                                 |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.                                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                                              |  |                                                 |  |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work                                                                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                                              |  |                                                 |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>Feb. 12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                         |  |                                                                                                     |  |                                                                                                                                                          |  |                                                                                              |  |                                                 |  |                             |  |
| 22b. SIGNATURE <u>Lloyd E. Saylor M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22c. DATE SIGNED <u>Feb. 13, 1969</u>                                                               |  | 22d. PHYSICIAN'S NAME (Type) Dr. Lloyd E. Saylor                                                                                                         |  |                                                                                              |  |                                                 |  |                             |  |
| 22e. ADDRESS 3902 Greenmount Avenue                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                     |  |                                                                                                                                                          |  |                                                                                              |  |                                                 |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 23b. DATE <u>2-15-1969</u>                                                                          |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>                                                                                         |  | 23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Balto. Co. Md.</u>                 |  |                                                 |  |                             |  |
| 24. FUNERAL DIRECTOR <u>Henry W. Jenkins &amp; Sons Co.</u>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                     |  | ADDRESS <u>21212 4905 York Rd. Balto. Md.</u>                                                                                                            |  | 25a. REC'D BY REGISTRAR <u>Feb 14 1969</u>                                                   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |                             |  |

05187

05187

05187



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

02158

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02153

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |  |                                                                                      |  |                  |                                                                                                                                                          |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------|--|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--|----------------------------------------------------------------------------------------------|--|-----------------------------|----------------------------------------------|-------------------------------------------------------|-----------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | First Middle Last                                                                    |  |                  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> 2 25 1969 7:30                                          |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 4. RACE                                                                              |  | 5. DATE OF BIRTH |                                                                                                                                                          | 6. AGE (in years last birthday) |  | IF UNDER 1 YEAR MONTHS DAYS                                                                  |  | IF UNDER 24 HRS. HOURS MIN. |                                              | 2c. DATE PRONOUNCED DEAD Month Day Year 25 19 69 7:30 |                             |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | White                                                                                |  | Aug. 1, 1914     |                                                                                                                                                          | 54 YRS.                         |  |                                                                                              |  |                             |                                              | 2d. HOUR                                              |                             |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                         |  |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH                                                                           |  |                             | Md.                                          |                                                       |                             |  |
| North Carolina                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  | USA                                                                                  |  |                  |                                                                                                                                                          |                                 |  | Balto.                                                                                       |  |                             |                                              |                                                       |                             |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)         |  |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                             |                                              |                                                       |                             |  |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 811 Seckel Ct.                                                                       |  |                  | Mechanic--Bus Co.                                                                                                                                        |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 13b. COUNTY                                                                          |  |                  | 13c. CITY OR TOWN                                                                                                                                        |                                 |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                             | 13e. STREET AND NUMBER                       |                                                       |                             |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | Balto.                                                                               |  |                  | Catonsville                                                                                                                                              |                                 |  |                                                                                              |  |                             | 811 Seckel Ct.                               |                                                       |                             |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 15. MOTHER'S MAIDEN NAME                                                             |  |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)                                                                                        |                                 |  | 16b. SOCIAL SECURITY NO.                                                                     |  |                             | 17. INFORMANT ADDRESS                        |                                                       |                             |  |
| Maurice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  | Underwood                                                                            |  |                  | Lesso                                                                                                                                                    |                                 |  | King                                                                                         |  |                             |                                              |                                                       |                             |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  | (If yes give war or dates of service)                                                |  |                  | 216-09-0289                                                                                                                                              |                                 |  | Mrs. Virginia M. Underwood                                                                   |  |                             | (Same)                                       |                                                       |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Gunshot wound of the chest<br>955X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                                                                                                                                                     |  |  |                                                                                      |  |                  |                                                                                                                                                          |                                 |  |                                                                                              |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                                                       |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                      |  |                  |                                                                                                                                                          |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |  |                  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                         |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 2 25 19 69                       |  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Self-inflicted gunshot wound of chest                                 |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                           |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Home |  |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>811 Seckel Ct. Catonsville Balto. Md.                                                    |                                 |  |                                                                                              |  |                             |                                              |                                                       |                             |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Edward F. Wilson, M.D.<br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) |  |  |                                                                                      |  |                  |                                                                                                                                                          |                                 |  |                                                                                              |  |                             |                                              |                                                       | 22b. DATE SIGNED<br>2/26/69 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  | 23b. DATE                                                                            |  |                  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                 |  | 23d. LOCATION (City or Town) (County) (State)                                                |  |                             |                                              |                                                       |                             |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  | 3/1/69.                                                                              |  |                  | Moreland Memorial Cemetery                                                                                                                               |                                 |  | Baltimore, Md.                                                                               |  |                             |                                              |                                                       |                             |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  | ADDRESS                                                                              |  |                  | 25a. REC'D BY REGISTRAR                                                                                                                                  |                                 |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |                             |                                              |                                                       |                             |  |
| Leonard J. Ruck, Inc. Balto. Md. 21214                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                      |  |                  | FEB 28 1969                                                                                                                                              |                                 |  | [Signature]                                                                                  |  |                             |                                              |                                                       |                             |  |

2180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15  
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                             |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                     |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                            |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 02154                                                                                                                                                                                                                                                                                                           |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                |  |  | First Middle Last                                                            |  |  | 2a. DATE OF DEATH                                                                                                                                        |  |  | 2b. HOUR                                                                                     |  |  |
| Luther                                                                                                                                                                                                                                                                                                          |  |  | S. UTERMÄHLEN                                                                |  |  | Month Day Year                                                                                                                                           |  |  | 4 <sup>15</sup> A.M.                                                                         |  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                          |  |  | 4. RACE                                                                      |  |  | 5. DATE OF BIRTH                                                                                                                                         |  |  | 6. AGE (In years lost birthday)                                                              |  |  |
| MALE                                                                                                                                                                                                                                                                                                            |  |  | WHITE                                                                        |  |  | 3-3-1881                                                                                                                                                 |  |  | 87 YRS.                                                                                      |  |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                       |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH                                                                           |  |  |
| MARYLAND                                                                                                                                                                                                                                                                                                        |  |  | U.S.A.                                                                       |  |  |                                                                                                                                                          |  |  | Baltimore Md.                                                                                |  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                       |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |  |
| Catonsville                                                                                                                                                                                                                                                                                                     |  |  | Spring Grove S. Hosp                                                         |  |  | FARMER                                                                                                                                                   |  |  | OWN FARM                                                                                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                   |  |  | 13b. COUNTY                                                                  |  |  | 13c. CITY OR TOWN                                                                                                                                        |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| Md.                                                                                                                                                                                                                                                                                                             |  |  | Baltimore                                                                    |  |  | Essex                                                                                                                                                    |  |  | 13e. STREET AND NUMBER                                                                       |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  |                                                                              |  |  |                                                                                                                                                          |  |  | 1300 Old Eastern Ave                                                                         |  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                               |  |  | 15. MOTHER'S MAIDEN NAME                                                     |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| First Middle Last                                                                                                                                                                                                                                                                                               |  |  | First Middle Last                                                            |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| HENRY UTERMÄHLEN                                                                                                                                                                                                                                                                                                |  |  | ANNIE HUMBERT                                                                |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)                                                                                                                                                                                                                                              |  |  | 16b. SOCIAL SECURITY NO.                                                     |  |  | 17. INFORMANT                                                                                                                                            |  |  |                                                                                              |  |  |
| No                                                                                                                                                                                                                                                                                                              |  |  | 215-14-1949                                                                  |  |  | Records: SPRING GROVE HOSP. OLD CHART. STATE HOSPITAL                                                                                                    |  |  |                                                                                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                       |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                    |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| IMMEDIATE CAUSE (a) Coronary insufficiency                                                                                                                                                                                                                                                                      |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                  |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| (b) Arteriosclerotic Cardio-vascular disease years                                                                                                                                                                                                                                                              |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                  |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| (c) Generalized Arteriosclerosis years                                                                                                                                                                                                                                                                          |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                             |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| Transitional cell CARCINOMA OF URINARY bladder                                                                                                                                                                                                                                                                  |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                          |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                              |  |  | 21b. TIME OF INJURY                                                          |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |  |                                                                                              |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  | HOUR A.M. Month Day Year                                                     |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>                                                                                                                                                        |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |  |                                                                                              |  |  |
|                                                                                                                                                                                                                                                                                                                 |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-23, 1967, to 2-25, 1969, that (H) (we) last saw the deceased alive on 2-25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                  |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                          |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 22c. DATE SIGNED                                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 2-25-1969                                                                                                                                                                                                                                                                                                       |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                    |  |  | 22e. ADDRESS                                                                 |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| JUAN A. PEREZ-BALBOA M.D.                                                                                                                                                                                                                                                                                       |  |  | Spring Grove State Hosp.                                                     |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                       |  |  | 23b. DATE                                                                    |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  |  | 23d. LOCATION (City or Town) (County) (State)                                                |  |  |
| Burial                                                                                                                                                                                                                                                                                                          |  |  | FEB 28 - 1969                                                                |  |  | BAUST C.E.M.                                                                                                                                             |  |  | WESTMINSTER RURAL MD                                                                         |  |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                            |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| ADDRESS UNION                                                                                                                                                                                                                                                                                                   |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 25a. REC'D BY REGISTRAR                                                                                                                                                                                                                                                                                         |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                      |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| DATE FEB 27 1969                                                                                                                                                                                                                                                                                                |  |  |                                                                              |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |

04124

CERTIFICATE OF DEATH

04124

RECEIVED  
FEB 1 1980

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-15-2000 BY 60322 UCBAW/STP



02160

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EFTIHIA</b>                                                                                                                                                                                                                                                                                                                                                                 |  |  | First Middle Last                                                                                          |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>February 11, 1969</b>                                                                                             |  |  | 2b. HOUR<br>M                                                                        |  |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 4. RACE<br><b>White</b>                                                                                    |  |  | 5. DATE OF BIRTH<br><b>January 21, 1887</b>                                                                                                                 |  |  | 6. AGE (In years last birthday)<br><b>82</b> YRS.                                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Turkey</b>                                                                                                                                                                                                                                                                                                                                                         |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                              |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Arbutus</b>                                                                                                                                                                                                                                                                                                                                                                        |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>1254 Greystone Road</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                   |  |  | 13b. COUNTY<br><b>Baltimore</b>                                                                            |  |  | 13c. CITY OR TOWN<br><b>Arbutus</b>                                                                                                                         |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>Theodore Balides</b>                                                                                                                                                                                                                                                                                                                                                  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Harriette</b>                                          |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                                                                                            |  |  | 16b. SOCIAL SECURITY NO.                                                                                   |  |  | 17. INFORMANT<br>Address<br><b>Mr. John A. Vafiades, 1254 Greystone Road</b>                                                                                |  |  |                                                                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sustained Hemorrhage</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>AS CVD to Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>glaucoma</b> |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus; Carcinoma of breast</b>                                                                                                                                                                                                                               |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                           |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                 |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                                                             |  |  |                                                                                      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                       |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/2</b> , 19 <b>63</b> to <b>12/11</b> , 19 <b>69</b> , that (I) (we) lost the deceased on <b>2-11</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                             |  |  |                                                                                                            |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |
| 22b. SIGNATURE<br><b>Earl Pass</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |  | DEGREE                                                                                                     |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>2-11-69</b>                                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Earl I. Pass</b>                                                                                                                                                                                                                                                                                                                                                                |  |  | 22e. ADDRESS<br><b>4001 Wilkens Avenue</b>                                                                 |  |  |                                                                                                                                                             |  |  |                                                                                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                         |  |  | 23b. DATE<br><b>2-15-1969</b>                                                                              |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greek Orthodox Cemetery</b>                                                                                        |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Windsor Mill Rd., Balto. Co.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>                                                                                                                                                                                                                                                                                                                               |  |  |                                                                                                            |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 13 1969</b>                                                                                                       |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02152

02152

02152

02152

02152

02152

02152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A10  
30M REV. 1-68

| 02161                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   | 02156                                                                                   |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------|-----------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|------------------------------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   | CERTIFICATE OF DEATH                                                                    |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Rose Louise Vicari</i>                                                                                                                                                                                                                                                                                                                              |  |  |                                            |  | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>13</i> Year <i>69</i>                                    |                                                                                                                                                             |  |  |                                                   | 2b. HOUR<br><i>8:00 PM</i>                                                              |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 3. SEX<br><i>F.</i>                                                                                                                                                                                                                                                                                                                                                                        |  |  | 4. RACE<br><i>W.</i>                       |  |                                                                                                     | 5. DATE OF BIRTH<br><i>8-14-1882</i>                                                                                                                        |  |  | 6. AGE (In years lost birthday)<br><i>86</i> YRS. |                                                                                         |  | IF UNDER 1 YEAR<br>MONTHS <i>0</i> DAYS <i>0</i> |  | IF UNDER 24 HRS.<br>HOURS <i>0</i> MIN. <i>0</i> |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>md</i>                                                                                                                                                                                                                                                                                                                                     |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |  |                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.        |                                                                                         |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cockeysville</i>                                                                                                                                                                                                                                                                                                                                           |  |  |                                            |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Masonic Home</i> |                                                                                                                                                             |  |  |                                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                                  |  |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                      |  |  |  |  |                                                      |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>                                                                                                                                                                                                                                                                                    |  |  |                                            |  | 13b. COUNTY <i>Baltimore</i>                                                                        |                                                                                                                                                             |  |  |                                                   | 13c. CITY OR TOWN <i>Baltimore</i>                                                      |  |                                                  |  |                                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                           |  |  |  |  | 13e. STREET AND NUMBER<br><i>6109 York Rd.</i>       |  |  |  |  |
| 14. FATHER'S NAME First <i>MASSIMO</i> Middle <i>Pisani</i> Last <i>Pisani</i>                                                                                                                                                                                                                                                                                                             |  |  |                                            |  | 15. MOTHER'S MAIDEN NAME First <i>ROSE</i> Middle <i>APPLE</i> Last <i>APPLE</i>                    |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)                                                                                                                                                                                                                                                                           |  |  |                                            |  | 16b. SOCIAL SECURITY NO.<br><i>220-54-6994</i>                                                      |                                                                                                                                                             |  |  |                                                   | 17. INFORMANT Address<br><i>Masonic Home Records</i>                                    |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arterio-Sclerotic Vas. Heart Disease</i><br><i>4124</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 yrs</i>                                                                           |  |  |  |  |                                                      |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                        |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                     |  |  |                                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                    |                                                                                                                                                             |  |  |                                                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |                                                  |  |                                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                   |  |  |  |  |                                                      |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                         |  |  |                                            |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <i>19</i><br>P.M. _____           |                                                                                                                                                             |  |  |                                                   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)         |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                             |  |  |                                            |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |                                                                                                                                                             |  |  |                                                   | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____    |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 1</i> , 19 <i>68</i> , to <i>Feb 13</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Feb 13</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  |                                                                                                                                        |  |  |  |  |                                                      |  |  |  |  |
| 22b. SIGNATURE<br><i>Carl F. Benson MD</i>                                                                                                                                                                                                                                                                                                                                                 |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED                                     |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Carl F. Benson MD</i>                                                                                                                                                                                                                                                                                                                                   |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  | 22e. ADDRESS<br><i>5111 York Rd Balt. Md 21212</i>                                                                                     |  |  |  |  |                                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, EMOVAL (Specify)<br><i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                  |  |  |                                            |  | 23b. DATE<br><i>Feb 15, 1969</i>                                                                    |                                                                                                                                                             |  |  |                                                   | 23c. NAME OF CEMETERY OR CREMATORIUM<br><i>Western Cemetery</i>                         |  |                                                  |  |                                                  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                                                            |  |  |  |  |                                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>WM. COOK - BROOK TOWSON, Towson Md 21204</i>                                                                                                                                                                                                                                                                                                                    |  |  |                                            |  |                                                                                                     |                                                                                                                                                             |  |  |                                                   |                                                                                         |  |                                                  |  |                                                  | 25a. REC'D BY REGISTRAR<br><i>FEB 18 1969</i>                                                                                          |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>William A. Cook</i> |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|
| 82162                                                                                                                                                                                                                                                                                                                                                                 |  | MARYLAND STATE DEPARTMENT OF HEALTH                                                                |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                           |  | 02157                                                                                              |  |
| Item 13 Film 410 3/5/69 kk                                                                                                                                                                                                                                                                                                                                            |  | CERTIFICATE OF DEATH                                                                               |  |
| 1. DECEASED-NAME (Type or print) <i>Peter</i>                                                                                                                                                                                                                                                                                                                         |  | 2a. DATE OF DEATH <i>Feb 20</i> Month <i>20</i> Day <i>69</i> Year                                 |  |
| 3. SEX <i>M</i>                                                                                                                                                                                                                                                                                                                                                       |  | 4. RACE <i>W.</i>                                                                                  |  |
| 5. DATE OF BIRTH <i>Dec 24, 1883</i>                                                                                                                                                                                                                                                                                                                                  |  | 6. AGE (In years last birthday) <i>85</i> YRS.                                                     |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto.</i>                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>                                                           |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                              |  | 9. COUNTY OF DEATH <i>Balto.</i>                                                                   |  |
| 10. CITY OR TOWN OF DEATH <i>Perry Hall</i>                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9409 Belair Rd</i> |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Merchant</i>                                                                                                                                                                                                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>                                                                                                                                                                                                                                                               |  | 13b. COUNTY <i>Balto</i>                                                                           |  |
| 13c. CITY OR TOWN <i>Perry Hall</i>                                                                                                                                                                                                                                                                                                                                   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  |
| 13e. STREET AND NUMBER <i>9409 Belair Road</i>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                    |  |
| 14. FATHER'S NAME First <i>Bartholomew</i> Middle <i>Violi</i> Last                                                                                                                                                                                                                                                                                                   |  | 15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>Meisenzahl</i> Last                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)                                                                                                                                                                                                                                                                                                    |  | 16b. SOCIAL SECURITY NO. <i>218-26-16394</i>                                                       |  |
| 17. INFORMANT <i>Mrs Marshall</i>                                                                                                                                                                                                                                                                                                                                     |  | Address <i>Same</i>                                                                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                             |  |                                                                                                    |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                    |  |
| IMMEDIATE CAUSE (a) <i>Massive pulmonary hemorrhage</i>                                                                                                                                                                                                                                                                                                               |  |                                                                                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                    |  |
| (b) <i>Pulmonary tumor (type undetermined)</i>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                    |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                    |  |                                                                                                    |  |
| <i>Arteriosclerotic heart disease</i>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                     |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>                                        |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                                                                                                                                                                                       |  |                                                                                                    |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work                                                                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  |
| 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                                                                                                                                                                                                                          |  |                                                                                                    |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>12/1/68</i> , 19__, to <i>2/20/69</i> , 19__, that (I) (we) last saw the deceased alive on <i>2/19/69</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death. |  |                                                                                                    |  |
| 22b. SIGNATURE <i>Theodore E. Evans</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                        |  | 22c. DATE SIGNED <i>2/21/69</i>                                                                    |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Dr. Theodore E. Evans</i>                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS <i>9660 Belair Road-36-Md.</i>                                                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>                                                                                                                                                                                                                                                                                                               |  | 23b. DATE <i>2/24/69</i>                                                                           |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>                                                                                                                                                                                                                                                                                                                    |  | 23d. LOCATION (City or Town) (County) (State) <i>Balto Co.</i>                                     |  |
| 24. FUNERAL DIRECTOR <i>H. Seemann</i> ADDRESS <i>6067 Huford Rd</i>                                                                                                                                                                                                                                                                                                  |  | 25a. REC'D BY REGISTRAR DATE <i>FEB 26 1969</i>                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                       |  | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>                                                      |  |

72120

STATE OF CALIF.

1915

1915

1915

1915

1915

1915



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 7-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                         |  |  |                                                                                                      |  |  |                                                                                                                                                             |  |  |                                                                                              |  |                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|------------------------------------------------------------|--|
| 02163                                                                                                                                                                                                                                                                                                               |  |  |                                                                                                      |  |  | CERTIFICATE OF DEATH                                                                                                                                        |  |  | 02158                                                                                        |  |                                                            |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Heinrich Leopold Volkman                                                                                                                                                                                                                                      |  |  |                                                                                                      |  |  | 2a. DATE OF DEATH Month Day Year<br>Feb 26 1969                                                                                                             |  |  | 2b. HOUR P M<br>3:45 P                                                                       |  |                                                            |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                      |  |  | 4. RACE<br>White                                                                                     |  |  | 5. DATE OF BIRTH<br>12-25-89                                                                                                                                |  |  | 6. AGE (In years lost birthday)<br>79 YRS.                                                   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Lithuania                                                                                                                                                                                                                                                              |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                                                  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                                          |  |                                                            |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                           |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Baltimore County Gen |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Pipe Fitter                                                      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B & O R. R.                                             |  |                                                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.                                                                                                                                                                                                                |  |  | 13b. CITY<br>Baltimore                                                                               |  |  | 13c. CITY OR TOWN<br>Marriottsville                                                                                                                         |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                                            |  |
| 14. FATHER'S NAME First Middle Last<br>Leopold Volkman                                                                                                                                                                                                                                                              |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Johanna unknown                                        |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br>No                                              |  |  | 16b. SOCIAL SECURITY NO.<br>705-05-2034                                                      |  |                                                            |  |
| 17. INFORMANT<br>Ewald F Volkman                                                                                                                                                                                                                                                                                    |  |  | 18. ADDRESS<br>Marriottsville Md. Address 21104<br>Bx 75A Riesburg Lane                              |  |  | 19. DATE OF OPERATION                                                                                                                                       |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                             |  |                                                            |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                 |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)          |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                         |  |                                                            |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                                                                                                                                     |  |  | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work       |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |                                                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 2, 1969, to Feb 26, 1969, that (I) (we) last saw the deceased alive on Feb 26, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  | 22b. SIGNATURE<br>Gregorio Nearfon, MD                                                               |  |  | 22c. DATE SIGNED<br>2-26-69                                                                                                                                 |  |  | 22d. PHYSICIAN'S NAME (Type)<br>Gregorio Nearfon                                             |  |                                                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                 |  |  | 23b. DATE<br>3-3-69                                                                                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto. City Baltimore Md.                   |  |                                                            |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard                                                                                                                                                                                                                                                                           |  |  | ADDRESS<br>4107 Wilkens Ave., 21229                                                                  |  |  | 25a. REC'D BY REGISTRAR<br>MAR 3 1969                                                                                                                       |  |  | 25b. REGISTRAR'S SIGNATURE<br>Clarence H. Young                                              |  |                                                            |  |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Aspiration pneumonia - Sudden  
4379  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) Chronic Brain Syndrome -> Coma  
DUE TO, OR AS A CONSEQUENCE OF  
(c) Cerebral Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

82138

OFFICE OF THE

NOTES

21

21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                       |  |                                                                                               |               |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                         |                                                        |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                   |  | First<br>B.                                                                                   | Middle<br>Roe | Last<br>Wallis                                                                                                                                              | 2a. DATE OF DEATH<br>Month 2 Day 23 Year 1969                                   |                                                                                                 | 2b. HOUR<br>5:00 P.M.                                                   |                                                        |                                                 |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                        |  | 4. RACE<br>Cau.                                                                               |               | 5. DATE OF BIRTH<br>1-20-1899                                                                                                                               |                                                                                 | 6. AGE (In years<br>last birthday)<br>70 YRS.                                                   |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |                                                 |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Kent Co. Md                                                                                                                                                                                                                                                                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                        |               | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                 | 9. COUNTY OF DEATH<br>Baltimore Md.                                                             |                                                                         |                                                        |                                                 |  |
| 10. CITY OR TOWN OF DEATH<br>Fallston Md.                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital<br>give street address) Lynch Terrace |               | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) Selfemployed                                                     |                                                                                 | 12b. KIND OF BUSINESS OR<br>INDUSTRY Farmer                                                     |                                                                         |                                                        |                                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.                                                                                                                                                                                                                                  |  | 13b. COUNTY Baltimore                                                                         |               | 13c. CITY OR TOWN<br>Fallston                                                                                                                               |                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                         | 13e. STREET AND NUMBER<br>Lynch Terrace Fallston 21047 |                                                 |  |
| 14. FATHER'S NAME<br>First Robert Middle L. Last Wallis                                                                                                                                                                                                                                                                               |  | 15. MOTHER'S MAIDEN NAME<br>First Mary Middle R. Last Roe                                     |               |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                                                                                                                                                                                                                                                                   |  | 16b. SOCIAL SECURITY NO.<br>217-36-1191A                                                      |               | 17. INFORMANT<br>Mildred M. Wallis Lynch Terrace Fallston, Md.                                                                                              |                                                                                 |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1991 Metastatic Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                               |               |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                         |                                                        | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                    |  |                                                                                               |               |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                              |               |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                                        |                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                    |               |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work of work                                                                                                                                                                                                                          |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)               |               |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from DECEMBER, 1968, to FEBRUARY, 1969, that (I) (we) lost<br>saw the deceased alive on February 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                                                                                               |               |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 22b. SIGNATURE<br>Kermit P. Bonovich, M.D.                                                                                                                                                                                                                                                                                            |  | DEGREE<br>ATTENDING<br>PHYS.                                                                  |               | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS.                                                                   |                                                                                 | 22c. DATE SIGNED<br>2-25-69                                                                     |                                                                         |                                                        |                                                 |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>KERMIT P. BONOVICH, M.D.                                                                                                                                                                                                                                                                           |  | 22e. ADDRESS<br>1916 Belair Rd. Fallston 21047                                                |               |                                                                                                                                                             |                                                                                 |                                                                                                 |                                                                         |                                                        |                                                 |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                |  | 23b. DATE<br>2-27-1969                                                                        |               | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                                                                                                     |                                                                                 | 23d. LOCATION (City or Town) (County) (State)<br>Parkville, Balto. Md.                          |                                                                         |                                                        |                                                 |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Belair Road 21236                                                                                                                                                                                                                                                                   |  |                                                                                               |               | ADDRESS                                                                                                                                                     |                                                                                 | 25a. REC'D BY REGISTRAR<br>DATE FEB 28 1969                                                     |                                                                         | 25b. REGISTRAR'S SIGNATURE<br>Charles J. [Signature]   |                                                 |  |

02120

UNITED STATES

02120

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE                                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  |                                                                                                                                                    |  |  |  |                                                                                                                                                          |  |                                                 |  | LAST                                                                                             |  | DATE OF DEATH |  |                   |  | HOUR |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|---------------|--|-------------------|--|------|--|
| 1. DECEASED-NAME (Type or print) <b>JOSEPH F. WALSH</b>                                                                                                                                                                                                                                                                                                                                               |  |                      |  |                                                                                                                                                    |  |  |  |                                                                                                                                                          |  |                                                 |  | 2a. DATE OF DEATH Month <b>2/8/69</b> Day <b>8</b> Year <b>1969</b>                              |  |               |  | 2b. HOUR <b>M</b> |  |      |  |
| 3. SEX <b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                    |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH <b>October 15th, 1890</b>                                                                                                         |  |  |  | 6. AGE (In years last birthday) <b>78</b> YRS.                                                                                                           |  | IF UNDER 1 YEAR MONTHS <b>78</b> DAYS <b>78</b> |  | IF UNDER 24 HRS. HOURS <b>78</b> MIN. <b>78</b>                                                  |  |               |  |                   |  |      |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Wilksburg, Pa.</b>                                                                                                                                                                                                                                                                                                                                       |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                            |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                 |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.                                                          |  |               |  |                   |  |      |  |
| 10. CITY OR TOWN OF DEATH <b>Phoenix, Balto. Co.</b>                                                                                                                                                                                                                                                                                                                                                  |  |                      |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Jarrettsville Pike</b>                                             |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Landscaping</b>                                               |  |                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                |  |               |  |                   |  |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                         |  |                      |  | 13b. COUNTY <b>Baltimore</b>                                                                                                                       |  |  |  | 13c. CITY OR TOWN <b>Phoenix</b>                                                                                                                         |  |                                                 |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |               |  |                   |  |      |  |
| 13e. STREET AND NUMBER <b>Jarrettsville Pike</b>                                                                                                                                                                                                                                                                                                                                                      |  |                      |  | 14. FATHER'S NAME First <b>Michael</b> Middle <b>Walsh</b> Last <b>Walsh</b>                                                                       |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Joanna</b> Middle <b>Harding</b> Last <b>Harding</b>                                                                   |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, if known <b>Yes</b> (If yes give branch and service) <b>WW-2</b>                                                                                                                                                                                                                                                                                    |  |                      |  | 16b. SOCIAL SECURITY NO. <b>215-07-3125</b>                                                                                                        |  |  |  | 17. INFORMANT <b>Mrs. Jean W. Bleckenstaff (daughter)</b>                                                                                                |  |                                                 |  | Address                                                                                          |  |               |  |                   |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4409 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                      |  |                                                                                                                                                    |  |  |  |                                                                                                                                                          |  |                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                     |  |               |  |                   |  |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                    |  |                      |  |                                                                                                                                                    |  |  |  |                                                                                                                                                          |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                   |  |                                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                             |  |               |  |                   |  |      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                    |  |                      |  | 21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>                                                               |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                              |  |                      |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                                                       |  |  |  | 21f. LOCATION Street or R.F.D. No. <b>Feb 6</b> City or Town <b>Feb 8</b> County <b>Feb 8</b> State <b>Feb 8</b>                                         |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 6</b> , 19 <b>67</b> , to <b>Feb 8</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb 8th</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |  |                      |  |                                                                                                                                                    |  |  |  |                                                                                                                                                          |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 22b. SIGNATURE <b>Henry L. McCorkle</b>                                                                                                                                                                                                                                                                                                                                                               |  |                      |  | DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>February 10th 1969</b>                                                                                                               |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Henry L. McCorkle</b>                                                                                                                                                                                                                                                                                                                                                 |  |                      |  | 22e. ADDRESS <b>Jacksonville, Md.</b>                                                                                                              |  |  |  |                                                                                                                                                          |  |                                                 |  |                                                                                                  |  |               |  |                   |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                               |  |                      |  | 23b. DATE <b>2/11/69</b>                                                                                                                           |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Gardens</b>                                                                                    |  |                                                 |  | 23d. LOCATION (City or Town) <b>Balto Co.</b> (County) <b>Balto Co.</b> (State) <b>Balto Co.</b> |  |               |  |                   |  |      |  |
| 24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd.</b>                                                                                                                                                                                                                                                                                                                                     |  |                      |  | ADDRESS <b>21212 FEB 14 1969</b>                                                                                                                   |  |  |  | 25a. REC'D BY REGISTRAR <b>Charles Judge</b>                                                                                                             |  |                                                 |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                                  |  |               |  |                   |  |      |  |

02180

DEPARTMENT OF STATE

02180

October 12, 1950

October 12, 1950

Washington

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation

Re: [Illegible]

Dear Sir:

Reference is made to your letter of October 10, 1950, regarding the above captioned matter.

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

Very truly yours,

John W. Blackwelder, Jr., Secretary

Enclosure

[Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (Rev. 1-58)

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                            |                                                              |                                                                                                                                                             |  |                                                                                                 |  |                                              |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                            |                                                              |                                                                                                                                                             |  |                                                                                                 |  |                                              |  |
| 1. DECEASED-NAME<br>(Type or print) Katie Ross Warner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            | 2a. DATE OF DEATH<br>Month FEB Day 25 Year 1969              |                                                                                                                                                             |  | 2b. HOUR<br>8:25 P M                                                                            |  |                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE<br>White                                                                                           |                                                              | 5. DATE OF BIRTH<br>11-30-80 81                                                                                                                             |  | 6. AGE (In years<br>lost birthday)<br>87 YRS                                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS            |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                       |                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore County Md.                                                      |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Baltimore Co. Gen. Hosp |                                                              | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>At Home                                                       |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                                            |  |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 13b. COUNTY Balto                                                                                          |                                                              | 13c. CITY OR TOWN<br>Baltimore                                                                                                                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>5820 Royal Oak Ave |  |
| 14. FATHER'S NAME First Middle Last<br>James Howeth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                            | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Emma Covington |                                                                                                                                                             |  |                                                                                                 |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16b. SOCIAL SECURITY NO.<br>None                                                                           |                                                              | 17. INFORMANT Address<br>Ethel Nolan-5107 Wesley Avenue 21207                                                                                               |  |                                                                                                 |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF THE ASCENDING COLON<br>1530 DUE TO, OR AS A CONSEQUENCE OF WITH LIVER METASTASIS<br>(b) AND COMPLETE INTESTINAL<br>DUE TO, OR AS A CONSEQUENCE OF OBSTRUCTION<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |                                                                                                            |                                                              |                                                                                                                                                             |  |                                                                                                 |  |                                              |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |                                                              |                                                                                                                                                             |  |                                                                                                 |  |                                              |  |
| 19a. DATE OF OPERATION<br>2-15-69                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>INTESTINAL OBSTRUCTION                                 |                                                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                                   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                 |                                                              | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                 |  |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |                                                              | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                                 |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-13-69, to 2-25-69, that (I) (we) last saw the deceased alive on 2-25-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                                     |  |                                                                                                            |                                                              |                                                                                                                                                             |  |                                                                                                 |  |                                              |  |
| 22b. SIGNATURE<br>Jesus G. Santana MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                            |                                                              | 22c. DATE SIGNED<br>2-25-69                                                                                                                                 |  | 22d. PHYSICIAN'S NAME (Type)<br>22e. ADDRESS                                                    |  |                                              |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 23b. DATE<br>2-28-69                                                                                       |                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery                                                                                                  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |                                              |  |
| 24. FUNERAL DIRECTOR<br>Marion P. Armacost-4600 Liberty Hts. Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                            |                                                              | 25a. REC'D BY REGISTRAR<br>DATE FEB 28 1969                                                                                                                 |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                                     |  |                                              |  |

2850

250

100 - 100 - 100

• •

100 J

100

1

• • • • •

10

1.25

1990

1.

[illegible]

101-2-10

266

( )

... and night

Venezuela, 1960-1970

۱۴۰۰

20-54-2

12170

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02167

CERTIFICATE OF DEATH

02162

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>WILBERT HERBERT WASHINGTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>18</b> Year <b>1969</b>                       |                                                                                 | 2b. HOUR<br><b>12:55</b>                                       |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4. RACE<br><b>Negro</b>                                                                                | 5. DATE OF BIRTH<br><b>OCTOBER 1 1897</b>                                                                                                                   |                                                                                                 | 6. AGE (In years<br>last birthday) <b>71</b> YRS.                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                          |                                                                                 |                                                                |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 11. NAME OF HOSPITAL <b>VETERANS ADMINISTRATION HOSPITAL</b><br>9140 W. JONES RD. BALTIMORE, MD. 21207 | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>GUARD</b>                                                  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>U.S. POST OFFICE</b>                                 |                                                                                 |                                                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                            | 13b. COUNTY <b>BALTIMORE</b>                                                                           | 13c. CITY OR TOWN<br><b>Catonsville</b>                                                                                                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>81 WINTERS AVENUE</b>                              |                                                                |
| 14. FATHER'S NAME First Middle Last<br><b>WILLIAM W. WASHINGTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY MUIR</b>                                  |                                                                                 |                                                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service)<br><b>WW-1</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 16b. SOCIAL SECURITY NO.<br><b>064 36 76 66</b>                                                                                                             | 17. INFORMANT Address<br><b>Clinical Rcds VA HOSPITAL, FORT HOWARD MD</b>                       |                                                                                 |                                                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM, ADVANCED</b><br><b>1541</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a).<br>stating the underlying cause<br>lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                                                                                                                |                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                 | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                                                |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                                                  |                                                                                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                                                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                                                             |                                                                                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |                                                                |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 26</b> , 19 <b>69</b> , to <b>Feb. 18</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>Feb. 18</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. <input checked="" type="checkbox"/> (we) (did) <del>view</del> view the body after death. |                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |
| 22b. SIGNATURE<br><b>Madhav D. Barhanpurkar</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                             |                                                                                                 | 22c. DATE SIGNED                                                                |                                                                |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>MADHAV D. BARHANPURKAR, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                             |                                                                                                 | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD MARYLAND</b>                        |                                                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 23b. DATE<br><b>2/21/69</b>                                                                                                                                 |                                                                                                 | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                 |                                                                |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                             |                                                                                                 |                                                                                 |                                                                |
| 24. FUNERAL DIRECTOR<br><b>Nutter Funeral Home</b><br>3035 W. North Avenue<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 24 1969</b>                                                                                                          |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                |                                                                |

03122

DEPARTMENT OF DEFENSE

03122

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

02168

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02163

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                    |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) <b>VINCENT</b>                                                                                                                                                                                                                                                                                                                                                        |  |  | First Middle Last                                                                                                                  |  |  | 2a. DATE OF DEATH                                                                                                                                        |  |  | 2b. HOUR                                                                                     |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                    |  |  | Month Day Year                                                                                                                                           |  |  | 11 40 M                                                                                      |  |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |  | 4. RACE <b>WHITE</b>                                                                                                               |  |  | 5. DATE OF BIRTH <b>5-1-83</b>                                                                                                                           |  |  | 6. AGE (In years lost birthday) <b>85</b> YRS.                                               |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                    |  |  |                                                                                                                                                          |  |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN                                                        |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>                                                                                                                                                                                                                                                                                                                                             |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                            |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <b>BALTIMORE</b>                                                          |  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Memorial Hosp. Home 501E TOWSON RD.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sailor</b>                                                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Nothing Co.</b>                                         |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Admission) STATE <b>Md.</b>                                                                                                                                                                                                                                                                                                                |  |  | 13b. COUNTY <b>BALTO.</b>                                                                                                          |  |  | 13c. CITY OR TOWN <b>TOWSON</b>                                                                                                                          |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER <b>1152 94PS4 Lane East</b>                                                                                                                                                                                                                                                                                                                                                     |  |  | 14. FATHER'S NAME First Middle Last <b>unknown</b>                                                                                 |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>                                                                                                |  |  |                                                                                              |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>                                                                                                                                                                                                                                                                                                                             |  |  | 16b. SOCIAL SECURITY NO. <b>215-03-5299</b>                                                                                        |  |  | 17. INFORMANT <b>DAUGHTER</b>                                                                                                                            |  |  | Address <b>1152 94PS4 Lane East TOWSON</b>                                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>150X</b><br>(b) <b>CARCINOMA ESOPHAGUS -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>2YR.</b> |  |  |                                                                                                                                    |  |  |                                                                                                                                                          |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21204</b>                                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                                    |  |  |                                                                                                                                    |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b>                                                                                                                                                                                                                                                                                                                                                        |  |  |                                                                                                                                    |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                 |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                     |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>                                                                             |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                                                          |  |  |                                                                                              |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                       |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |  |                                                                                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/5/66</b> , 19__, to <b>2/14/69</b> , that (I) (we) lost the deceased alive on <b>2/14/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                        |  |  |                                                                                                                                    |  |  |                                                                                                                                                          |  |  |                                                                                              |  |  |
| 22b. SIGNATURE <b>Donald O Wood M.D.</b>                                                                                                                                                                                                                                                                                                                                                               |  |  | 22c. DATE SIGNED <b>2-15-69</b>                                                                                                    |  |  | 22d. PHYSICIAN'S NAME (Type) <b>Donald O. Wood M.D.</b>                                                                                                  |  |  | 22e. ADDRESS <b>York Rd. &amp; Greenmeadow Dr. Timonium Md.</b>                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                |  |  | 23b. DATE <b>2/18/69</b>                                                                                                           |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>                                                                                             |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>                              |  |  |
| 24. FUNERAL DIRECTOR <b>John J. Cowan, Jr. Inc. 901 Holliston St. (21223)</b>                                                                                                                                                                                                                                                                                                                          |  |  | 25a. REC'D BY REGISTRAR <b>FFP 17</b>                                                                                              |  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Cowan, Jr.</b>                                                                                                     |  |  |                                                                                              |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02164

CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                   |  |                      |                                                                                                          |                                  |  |                                                                                                                                                          |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|----------------------------------------------------------------------------------------------------------|----------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|-----------------------------------------------------------------|--|--|
| 1. DECEASED-NAME (Type or print) <b>ERNEST MILTON WATSON, SR</b>                                                                                                                                                                                                                                                                                                                  |  |                      | 2a. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>2</b> Year <b>1969</b>                                 |                                  |  | 2b. HOUR <b>11<sup>35</sup> P M</b>                                                                                                                      |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
| 3. SEX <b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                |  | 4. RACE <b>NEGRO</b> |                                                                                                          | 5. DATE OF BIRTH <b>12/22/93</b> |  | 6. AGE (In years last birthday) <b>75</b> YRS.                                                                                                           |  | 7. UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |                                                                                              | 8. UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>            |  |                                                                 |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>SOUTH CAROLINA</b>                                                                                                                                                                                                                                                                                                                   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                                                                 |                                  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                                  | 9. COUNTY OF DEATH <b>Baltimore County,</b> Md.                                              |                                                             |  |                                                                 |  |  |
| 10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>                                                                                                                                                                                                                                                                                                                                     |  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b> |                                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>                                                   |  |                                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                                             |  |                                                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>                                                                                                                                                                                                                                                                     |  |                      | 13b. COUNTY <b>BALTIMORE</b>                                                                             |                                  |  | 13c. CITY OR TOWN <b>BALTIMORE</b>                                                                                                                       |  |                                                  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                             |  | 13e. STREET AND NUMBER <b>1238 EAST EAGER STREET</b>            |  |  |
| 14. FATHER'S NAME First <b>CHARLES</b> Middle <b>WATSON</b> Last <b>WATSON</b>                                                                                                                                                                                                                                                                                                    |  |                      | 15. MOTHER'S MAIDEN NAME First <b>ANNIE</b> Middle <b>(?)</b> Last <b>(?)</b>                            |                                  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)                                         |  |                                                  | 16b. SOCIAL SECURITY NO. <b>216-03-4686-A</b>                                                |                                                             |  | 17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>0112</b> IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                      |                                                                                                          |                                  |  |                                                                                                                                                          |  |                                                  |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b> |  |                                                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes mellitus</b>                                                                                                                                                                                                                    |  |                      |                                                                                                          |                                  |  |                                                                                                                                                          |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                            |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                         |                                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  |                                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                                             |  |                                                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                |  |                      | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                        |                                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                      |  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 8, 1968</b> , to <b>FEBRUARY 2, 1969</b> , that (I) (we) last saw the deceased alive on <b>2/2</b> <b>1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |                      |                                                                                                          |                                  |  |                                                                                                                                                          |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
| 22b. SIGNATURE <b>William Newcomer</b>                                                                                                                                                                                                                                                                                                                                            |  |                      |                                                                                                          |                                  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |                                                  | 22c. DATE SIGNED                                                                             |                                                             |  |                                                                 |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>                                                                                                                                                                                                                                                                                                                        |  |                      |                                                                                                          |                                  |  | 22e. ADDRESS <b>Mount Wilson, Maryland</b>                                                                                                               |  |                                                  |                                                                                              |                                                             |  |                                                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                                           |  |                      | 23b. DATE <b>2-6-69</b>                                                                                  |                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt CALVARY CEM</b>                                                                                                 |  |                                                  | 23d. LOCATION (City or Town) (County) (State) <b>A.A. Co. Maryland</b>                       |                                                             |  |                                                                 |  |  |
| 24. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr. Harford Ave.</b>                                                                                                                                                                                                                                                                                                                   |  |                      |                                                                                                          |                                  |  | ADDRESS <b>1735</b>                                                                                                                                      |  |                                                  | 25a. REC'D BY REGISTRAR <b>FEB 4 1969</b>                                                    |                                                             |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>              |  |  |

Baltimore County

Wm. Wilson St. Hosp.

House of Son

Wm. Wilson St. Hosp.

1918

Wm. Wilson St. Hosp.

House of Son

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02170

02165

|                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                             |                                                                                                                                                             |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------|---------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MATILDA Byrd WATSON</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                           | 2a. DATE OF DEATH<br><b>February</b> Month <b>14</b> , Day <b>1969</b> Year |                                                                                                                                                             |                                                                                                                | 2b. HOUR<br><b>10 P.M.</b>                                                                                                      |                                                                         |                                                                   |         |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>White</b>                                                                                   |                                                                             | 5. DATE OF BIRTH<br><b>2/26/1887</b>                                                                                                                        |                                                                                                                | 6. AGE (In years<br>last birthday)<br><b>81</b> YRS.                                                                            |                                                                         | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN   |         |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                |                                                                             | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                                      |                                                                         |                                                                   |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lochearn</b>                                                                                                                                                                                                                                                                                                                                |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>4109 Essex Road</b> |                                                                             |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b> |                                                                                                                                 |                                                                         | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>--</b>                 |         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                         |  | 13b. COUNTY<br><b>Worcester</b>                                                                           |                                                                             | 13c. CITY OR TOWN<br><b>Pocomoke</b>                                                                                                                        |                                                                                                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |                                                                         | 13e. STREET AND NUMBER<br><b>926 Second Street</b>                |         |  |
| 14. FATHER'S NAME First Middle Last<br><b>Thomas T. Byrd</b>                                                                                                                                                                                                                                                                                                                |  |                                                                                                           | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth -- Turner</b>    |                                                                                                                                                             |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                       |  |                                                                                                           | 16b. SOCIAL SECURITY NO.<br><b>213-50-8665</b>                              |                                                                                                                                                             | 17. INFORMANT<br><b>Watson Funeral Home, Pocomoke City, Md.</b>                                                |                                                                                                                                 |                                                                         |                                                                   | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HASCUO</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |                                                                                                           |                                                                             |                                                                                                                                                             |                                                                                                                |                                                                                                                                 |                                                                         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>20 YRS.</b> |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>none</b>                                                                                                                                                                                                                           |  |                                                                                                           |                                                                             |                                                                                                                                                             |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |                                                                             |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |                                                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                                                   |         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                    |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                         |                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1-27, 1969</b> , to <b>1-14, 1969</b> , that (1) (we) last saw the deceased alive on <b>2-10, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                     |  |                                                                                                           |                                                                             |                                                                                                                                                             |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
| 22b. SIGNATURE<br><b>Lawrence Solomon</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                           |                                                                             | DEGREE<br><b>MD</b>                                                                                                                                         |                                                                                                                | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                         | 22c. DATE-SIGNED<br><b>2/15/69</b>                                |         |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Lawrence F. Solomon</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                           |                                                                             | 22e. ADDRESS<br><b>3600 Lochearn Drive, Baltimore, Md.</b>                                                                                                  |                                                                                                                |                                                                                                                                 |                                                                         |                                                                   |         |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                               |  | 23b. DATE<br><b>2-16-1969</b>                                                                             |                                                                             | 23c. NAME OF CEMETERY<br><b>Salem Methodist</b>                                                                                                             |                                                                                                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocomoke City-Wor.-Md.</b>                                                  |                                                                         |                                                                   |         |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                             | ADDRESS<br><b>Pocomoke City, Md.</b>                                                                                                                        |                                                                                                                | 25a. REC'D BY REGISTRAR<br><b>FEB 18 1969</b>                                                                                   |                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>William V. Vande...</b>          |         |  |

02130

02135

ATBOM

For ter

1

W-10

4000

1

1000

1000

1000

1000

1000

1000

1000

1000



1000

1000

1000

1000

1000

1000

1000

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02171

02166

|                                                                                                                                                                                                                                                                                                                                                              |                          |                                                                                                                                                                                                                                                               |                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. NAME OF DECEASED<br>(Type or Print) <b>RAE WAXMAN</b><br><b>(RACHAEL)</b>                                                                                                                                                                                                                                                                                 |                          | 2. DATE AND HOUR OF DEATH<br><b>FEBRUARY 13, 1969</b> <b>10:15 P.M.</b>                                                                                                                                                                                       |                                                                          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>BALTIMORE COUNTY</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>7010 CONCORD ROAD</b>                                                                                                                                   |                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Balto.</b>                                                                                                                  |                                                                          |
| 5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b>                                                                                                                                                                                                                                                                                                                    |                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                      |                                                                          |
| 8. DATE OF BIRTH <b>10-4-1910</b>                                                                                                                                                                                                                                                                                                                            |                          | 9. AGE (In years lost birthday) <b>58</b>                                                                                                                                                                                                                     |                                                                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>                                                                                                                                                                                                                                                 |                          | 10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>                                                                                                                                                                                                              |                                                                          |
| 11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>                                                                                                                                                                                                                                                                                         |                          | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                                                                                                                                                                                    |                                                                          |
| 13. FATHER'S NAME <b>AARON KURTZWILE</b>                                                                                                                                                                                                                                                                                                                     |                          | 14. MOTHER'S MAIDEN NAME <b>LIZZIE ?</b>                                                                                                                                                                                                                      |                                                                          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>                                                                                                                                                                                                                                           |                          | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                       |                                                                          |
| 17. INFORMANT <b>MRS. BEVERLY BAUMOHL, 7010 CONCORD ROAD #8</b>                                                                                                                                                                                                                                                                                              |                          | ADDRESS                                                                                                                                                                                                                                                       |                                                                          |
| 18. I <b>I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>2509 ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                          | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial infarction 1 hr</b><br>(B) <b>Chronic ASHD, generalized atherosclerosis 10 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF: <b>28 yrs</b><br>(C) <b>diabetes mellitus</b> |                                                                          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL                                                                                                                                                                                                                                                                 |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                                                                                  |                                                                          |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2/13 1969</b> to <b>2/13 1969</b> , that (I) (we) last saw the deceased alive on <b>2/13 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                              |                          |                                                                                                                                                                                                                                                               |                                                                          |
| 23A. SIGNATURE <b>Stanley M. Rosen M.D.</b><br>DEGREE                                                                                                                                                                                                                                                                                                        |                          | 23B. DATE SIGNED <b>2/14/69</b>                                                                                                                                                                                                                               |                                                                          |
| 23C. PHYSICIAN'S NAME (Type) <b>STANLEY M. ROSEN</b><br>DEGREE                                                                                                                                                                                                                                                                                               |                          | 23D. ADDRESS <b>4000 W. NORTHERN PARKWAY</b>                                                                                                                                                                                                                  |                                                                          |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>                                                                                                                                                                                                                                                                                                       | 24B. DATE <b>2-16-69</b> | 24C. NAME of CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>                                                                                                                                                                                                    | 24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b> |
| 25A. DATE REC'D BY HEALTH DEPT. <b>FEB 18 1969</b>                                                                                                                                                                                                                                                                                                           |                          | 25B. NAME OF REGISTRAR <b>Charles Judge</b>                                                                                                                                                                                                                   |                                                                          |
| 25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>                                                                                                                                                                                                                                                                                |                          | ADDRESS                                                                                                                                                                                                                                                       |                                                                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|----------------------------------------------|--|
| 02172                                                                                                                                                                                                                                                                                                                                                                                   |  | MARYLAND STATE DEPARTMENT OF HEALTH                                          |  |                                                                                                                                                          |  | 02167                                                                                        |  |                                                                      |  |                                              |  |
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                             |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |  | First Middle Last                                                                                                                                        |  | 2a. DATE OF DEATH                                                                            |  |                                                                      |  | 2b. HOUR                                     |  |
| WILMA                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |  | BIRELEY                                                                                                                                                  |  | 2 Month 8 Day 69 Year                                                                        |  |                                                                      |  | 11:30 P.M.                                   |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (In years last birthday)                                                              |  | IF UNDER 1 YEAR                                                      |  | IF UNDER 24 HRS.                             |  |
| FEMALE                                                                                                                                                                                                                                                                                                                                                                                  |  | white                                                                        |  | Sept. 17, 1921                                                                                                                                           |  | 47 YRS.                                                                                      |  | MONTHS DAYS                                                          |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                               |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                                           |  |                                                                      |  |                                              |  |
| Penna.                                                                                                                                                                                                                                                                                                                                                                                  |  | U.S.A.                                                                       |  |                                                                                                                                                          |  | BALTIMORE Co.                                                                                |  |                                                                      |  |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                               |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                                                                      |  |                                              |  |
| TOWSON                                                                                                                                                                                                                                                                                                                                                                                  |  | GREAT. BALT. MED. CEN.                                                       |  | School Teacher                                                                                                                                           |  | Schools                                                                                      |  |                                                                      |  |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                           |  | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                               |  |                                              |  |
| Pa.                                                                                                                                                                                                                                                                                                                                                                                     |  | Franklin                                                                     |  | Greencastle                                                                                                                                              |  |                                                                                              |  | 147 N. Allison St.                                                   |  |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |  | First Middle Last                                                                                                                                        |  | 15. MOTHER'S MAIDEN NAME                                                                     |  |                                                                      |  | First Middle Last                            |  |
| E. Royer Weagley                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |  |                                                                                                                                                          |  | Bertha Fintrick                                                                              |  |                                                                      |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                                                                                                                                                                                                                                                                                      |  |                                                                              |  | 16b. SOCIAL SECURITY NO.                                                                                                                                 |  | 17. INFORMANT                                                                                |  | Address                                                              |  |                                              |  |
| No                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                              |  | 193-12-9036                                                                                                                                              |  | Mrs Gail Krumer                                                                              |  | Greencastle, Pa.                                                     |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                               |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                            |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| IMMEDIATE CAUSE (a) LIVER FAILURE                                                                                                                                                                                                                                                                                                                                                       |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 570X DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| (b) ACUTE YELLOW ATROPHY                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| (c)                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                     |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| MUCOEPIDERMOID CARCINOMA OF PAROTID GLAND                                                                                                                                                                                                                                                                                                                                               |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                                                                                                                                          |  | 20a. AUTOPSY?                                                                                |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                                                                                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |                                                                      |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY                                                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  | HOUR A.M. Month Day Year P.M. 19                                             |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 21d. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                    |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION                                                                                                                                            |  | Street or R.F.D. No.                                                                         |  | City or Town                                                         |  | County State                                 |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                     |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 8, 1969, to Feb. 8, 1969, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Feb. 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                          |  | 22c. DATE SIGNED                                                             |  |                                                                                                                                                          |  | 22d. PHYSICIAN'S NAME (Type)                                                                 |  |                                                                      |  |                                              |  |
| Charles C. Brown, M.D.                                                                                                                                                                                                                                                                                                                                                                  |  | 2-9-69                                                                       |  |                                                                                                                                                          |  | Dr. Charles C. BROWN, M.D.                                                                   |  |                                                                      |  |                                              |  |
| 22e. ADDRESS                                                                                                                                                                                                                                                                                                                                                                            |  | 22f. ADDRESS                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 6701 N. Charles St.                                                                                                                                                                                                                                                                                                                                                                     |  | 21204                                                                        |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                               |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)                                                |  |                                                                      |  |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                  |  | 2/12/69                                                                      |  | Cedar Hill Cem.                                                                                                                                          |  | Greencastle Pa.                                                                              |  |                                                                      |  |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                    |  | 25a. RECEIVED BY REGISTRAR                                                   |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| A. E. Munnich - Greencastle, Pa.                                                                                                                                                                                                                                                                                                                                                        |  | FEB 11 1969                                                                  |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
| 25b. REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                              |  | DATE                                                                         |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                                                                      |  |                                              |  |

5315

5150

55

27

5

6

27-5-72

7-11221-12

/

25

החלפת

100. 7

THE UNIVERSITY OF CHICAGO

CONFIDENTIAL

9-10

1. 2. 3.

35.25

100

 $22.5^{\circ} = 22.5^{\circ}$ 

CSAC . 50 . 0015 . 10 72

CONFIDENTIAL

100

100

12. 11. 2011

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>6</div> <div>1</div> <div>02173</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02168</div>                                                                                                                                                     |  |                                                                              |                                                                                                               |                                                                                                                                                             |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|-------------------------------------------------------------|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>Theresa C. Weber</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                               |                                                                                                                                                             |                                                                                      | 2a. DATE OF DEATH<br><b>February 9, 1969</b>                                                                |                                                                                                 |  | 2b. HOUR<br><b>4:30</b> M                               |                                                             |                                |
| 3. SEX<br><b>female</b>                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br><b>white</b>                                                      |                                                                                                               | 5. DATE OF BIRTH<br><b>Aug. 15, 1901</b>                                                                                                                    |                                                                                      |                                                                                                             | 6. AGE (In years last birthday)<br><b>67</b> YRS.                                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS                          |                                                             | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Scranton, Pa.</b>                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |                                                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                      | 9. COUNTY OF DEATH<br><b>Baltimore County</b>                                                               |                                                                                                 |  | Md.                                                     |                                                             |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>                                                                                                                                                                                                                                                                                                                                         |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>3006 1/2 Lavender Ave.</b> |                                                                                                                                                             |                                                                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |                                                                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At. Home</b>    |                                                             |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                      |  |                                                                              | 13b. COUNTY<br><b>Baltimore</b>                                                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br><b>Parkville</b>                                                |                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3006 1/2 Lavender Ave.</b> |                                                             |                                |
| 14. FATHER'S NAME First Middle Last<br><b>John Sheridan</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                               | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Theresa Daily</b>                                                                                          |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>                                                                                                                                                                                                                                                                                                       |  |                                                                              | 16b. SOCIAL SECURITY NO.<br><b>207-01-42464</b>                                                               |                                                                                                                                                             | 17. INFORMANT Address<br><b>Wilfred B. Weber 3002 Hiss Ave.</b>                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>4123</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                              |                                                                                                               |                                                                                                                                                             |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yrs.</b> |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                        |  |                                                                              |                                                                                                               |                                                                                                                                                             |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                               |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |                                                         |                                                             |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                              |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |                                                                                                               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                        |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                               | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 5, 1966</b> , to <b>Feb 8, 1969</b> , that (I) (we) last saw the deceased alive on <b>Feb. 8, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                           |  |                                                                              |                                                                                                               |                                                                                                                                                             |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 22b. SIGNATURE<br><b>Sebastian Russo</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                               | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                                                                                      | 22c. DATE SIGNED<br><b>Feb 10, 1969</b>                                                                     |                                                                                                 |  |                                                         |                                                             |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Sebastian Russo</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                               | 22e. ADDRESS<br><b>5017 Harford Road</b>                                                                                                                    |                                                                                      |                                                                                                             |                                                                                                 |  |                                                         |                                                             |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>                                                                                                                                                                                                                                                                                                                            |  | 23b. DATE<br><b>Feb 12, 1969</b>                                             |                                                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem</b>                                                                                           |                                                                                      |                                                                                                             | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co. Md.</b>                       |  |                                                         |                                                             |                                |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Dippel Brothers Inc. 7110 Belair Rd.</b>                                                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                                                               | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1969</b>                                                                                                          |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>                                                       |                                                                                                 |  |                                                         |                                                             |                                |

05108

RECEIVED

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
-Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (10)  
30M REV. 1-68

| 02174                                                                                                                                                                                                                                                                                                                                                                                                             |  |                              |                                                                              | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                          |                                    |                                                                                                                                           |                                                                                              | 02169                                         |                                                                      |                                                             |                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------|------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                               |  |                              |                                                                              | First                                                                                                                                                       | Middle                             | Lost                                                                                                                                      | 20. DATE OF DEATH                                                                            |                                               |                                                                      |                                                             | 2b. HOUR         |  |
| JULIUS                                                                                                                                                                                                                                                                                                                                                                                                            |  |                              |                                                                              |                                                                                                                                                             |                                    | WEINSTEIN                                                                                                                                 | Month                                                                                        | Day                                           | Year                                                                 | 6:03 PM                                                     |                  |  |
| FEB                                                                                                                                                                                                                                                                                                                                                                                                               |  |                              |                                                                              | 3                                                                                                                                                           |                                    | 1969                                                                                                                                      |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                            |                                    |                                                                                                                                           | 6. AGE (In years last birthday)                                                              |                                               | IF UNDER 1 YEAR                                                      |                                                             | IF UNDER 24 HRS. |  |
| MALE                                                                                                                                                                                                                                                                                                                                                                                                              |  | WHITE                        |                                                                              |                                                                                                                                                             |                                    |                                                                                                                                           | 64 YRS.                                                                                      |                                               | MONTHS                                                               |                                                             | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                         |  | 7b. CITIZEN OF WHAT COUNTRY? |                                                                              | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |                                                                                                                                           | 9. COUNTY OF DEATH                                                                           |                                               |                                                                      |                                                             |                  |  |
| MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                          |  | U.S.                         |                                                                              |                                                                                                                                                             |                                    |                                                                                                                                           | Baltimore County, Md.                                                                        |                                               |                                                                      |                                                             |                  |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                         |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                             |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)                                                    |                                                                                              |                                               | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                                             |                  |  |
| Mount Wilson                                                                                                                                                                                                                                                                                                                                                                                                      |  |                              | Mt. Wilson St. Hosp.                                                         |                                                                                                                                                             |                                    | NIGHT WATCHMAN                                                                                                                            |                                                                                              |                                               | FUNERAL HOME                                                         |                                                             |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                     |  |                              | 13b. COUNTY                                                                  |                                                                                                                                                             | 13c. CITY OR TOWN                  |                                                                                                                                           | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                               | 13e. STREET AND NUMBER                                               |                                                             |                  |  |
| MD                                                                                                                                                                                                                                                                                                                                                                                                                |  |                              | BALTIMORE                                                                    |                                                                                                                                                             | BALTIMORE                          |                                                                                                                                           |                                                                                              |                                               | 222 WYNDMOOR PL                                                      |                                                             |                  |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                 |  |                              | First                                                                        | Middle                                                                                                                                                      | Lost                               | 15. MOTHER'S MAIDEN NAME                                                                                                                  |                                                                                              |                                               | First                                                                | Middle                                                      | Lost             |  |
| MAX                                                                                                                                                                                                                                                                                                                                                                                                               |  |                              |                                                                              |                                                                                                                                                             | WEINSTEIN                          | YETTA                                                                                                                                     |                                                                                              |                                               |                                                                      |                                                             | ZALIS            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                                                                                                                                  |  |                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                             |                                    | 17. INFORMANT                                                                                                                             |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| NO                                                                                                                                                                                                                                                                                                                                                                                                                |  |                              | 212-01-5733                                                                  |                                                                                                                                                             |                                    | MRS. ADELE WEINSTEIN, 222 WYNDMOOR PL.                                                                                                    |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE AIRWAY DISEASE<br>517X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) PULMONARY FIBROSIS, UNKNOWN ETIOLOGY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) COR PULMONALE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |                              |                                                                              |                                                                                                                                                             |                                    |                                                                                                                                           |                                                                                              |                                               |                                                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 yr 6 mos. |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                               |  |                              |                                                                              |                                                                                                                                                             |                                    |                                                                                                                                           |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                            |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                                                                             |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                              |                                               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                             |                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                          |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                                                                             |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                           |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                    |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                                                                             |                                    | 21f. LOCATION                                                                                                                             |                                                                                              |                                               | Street or R.F.D. No.                                                 | City or Town                                                | County           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                              |                                                                              |                                                                                                                                                             |                                    |                                                                                                                                           |                                                                                              |                                               |                                                                      |                                                             | State            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/16, 1969, to 2/3, 1969, that (I) (we) last saw the deceased alive on 2/3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                     |  |                              |                                                                              |                                                                                                                                                             |                                    |                                                                                                                                           |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| 22b. SIGNATURE<br>William Newcomer                                                                                                                                                                                                                                                                                                                                                                                |  |                              |                                                                              |                                                                                                                                                             |                                    | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                              |                                               | 22c. DATE SIGNED<br>2/3/69                                           |                                                             |                  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>William Newcomer, M.D.                                                                                                                                                                                                                                                                                                                                                            |  |                              |                                                                              |                                                                                                                                                             |                                    | 22e. ADDRESS<br>Mount Wilson, Maryland                                                                                                    |                                                                                              |                                               |                                                                      |                                                             |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                         |  |                              | 23b. DATE                                                                    |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY |                                                                                                                                           |                                                                                              | 23d. LOCATION (City or Town) (County) (State) |                                                                      |                                                             |                  |  |
| BURIAL                                                                                                                                                                                                                                                                                                                                                                                                            |  |                              | 2-4-69                                                                       |                                                                                                                                                             | NEW HAR SINAI                      |                                                                                                                                           |                                                                                              | GARRISON, MARYLAND                            |                                                                      |                                                             |                  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                                                                                              |  |                              |                                                                              |                                                                                                                                                             |                                    | 25a. REC'D BY REGISTRAR<br>DATE FEB 6 1969                                                                                                |                                                                                              |                                               | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |                                                             |                  |  |

Belmont County

June 1, 1933

Belmont County

June 1, 1933

U.S. DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/80

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                       |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|--|
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                       |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                 |  |  | First<br>Emma                                                                                         |  | Middle<br>A                                                                                                                                                 |                                                                                                                                 | Last<br>Welch                                                                        |                                                                                       | 2a. DATE OF DEATH<br>Month 2 Day 21 Year 69           |                                              |  |
| 3. SEX<br>Female                                                                                                                                                                                                                                                                                                                                                                    |  |  | 4. RACE<br>White                                                                                      |  | 5. DATE OF BIRTH<br>August 5, 1874                                                                                                                          |                                                                                                                                 |                                                                                      | 6. AGE (In years last birthday)<br>94 YRS.                                            |                                                       | 2b. HOUR<br>11:30 M.                         |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                               |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                 |                                                                                      | 9. COUNTY OF DEATH<br>Baltimore                                                       |                                                       | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville                                                                                                                                                                                                                                                                                                                                            |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Paradise Nursing Home |  |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife                            |                                                                                      |                                                                                       | 12b. KIND OF BUSINESS OR INDUSTRY                     |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland                                                                                                                                                                                                                                                                           |  |  | 13b. COUNTY<br>—                                                                                      |  | 13c. CITY OR TOWN<br>Morrell Park                                                                                                                           |                                                                                                                                 | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                                       | 13e. STREET AND NUMBER<br>2453 Washington Blvd. 21230 |                                              |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Elijah Smith                                                                                                                                                                                                                                                                                                                              |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Josephine Huber                                      |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>No                                                                                                                                                                                                                                                                                                         |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                     |  | 17. INFORMANT<br>Address<br>Mrs. Pearl M. Webster, 2453 Washington Blvd.                                                                                    |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |                                                                                                       |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                  |  |  |                                                                                                       |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                      |  |                                                                                                                                                             | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                       |                                                                                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |                                                       |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                            |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                            |  |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                        |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                    |                                                                                      |                                                                                       |                                                       |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-31, 1968, to 2-21, 1969, that (I) (we) last saw the deceased alive on 1-7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                     |  |  |                                                                                                       |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 22b. SIGNATURE<br>D. Sorongon                                                                                                                                                                                                                                                                                                                                                       |  |  | DEGREE                                                                                                |  |                                                                                                                                                             | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                      |                                                                                       | 22c. DATE SIGNED<br>2-21-69                           |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DOMINGO C. SORONGON                                                                                                                                                                                                                                                                                                                                 |  |  | 22e. ADDRESS<br>3915 HOLLINS FERRY RD.<br>BALTO., MD. 21227                                           |  |                                                                                                                                                             |                                                                                                                                 |                                                                                      |                                                                                       |                                                       |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                 |  |  | 23b. DATE<br>2-24-1969                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                  |                                                                                                                                 |                                                                                      | 23d. LOCATION (City or Town) (County) (State) Md.<br>3801 Frederick Ave., Balto., Md. |                                                       |                                              |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave.                                                                                                                                                                                                                                                                                                                        |  |  | ADDRESS<br>21229                                                                                      |  |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br>FEB 25 1969                                                                                          |                                                                                      |                                                                                       | 25b. REGISTRAR'S SIGNATURE<br>William Judge           |                                              |  |

MEDICAL CERTIFICATION

02170

02170

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                           |                                                                        |                                                                                                                                                             |  |                                                                                      |  |                                                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                           |                                                                        |                                                                                                                                                             |  |                                                                                      |  |                                                                                 |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                           |                                                                        |                                                                                                                                                             |  |                                                                                      |  |                                                                                 |  |
| 1. DECEASED NAME<br>(Type or print) <b>LULA E. WIDERMANN</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                           | 20. DATE OF DEATH<br>Month <b>FEB</b> Day <b>9</b> Year <b>1969</b>    |                                                                                                                                                             |  | 2b. HOUR <b>11 A M</b>                                                               |  |                                                                                 |  |
| 3. SEX<br><b>FEMALE</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><b>White</b>                                                                                   |                                                                        | 5. DATE OF BIRTH<br><b>7-20-93</b>                                                                                                                          |  | 6. AGE (In years last birthday)<br><b>75 YRS.</b>                                    |  | IF UNDER 1 YEAR<br>MONTHS <b>75</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Life</b>                                                               |                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Balto.</b>                                                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TOWSON Md.</b>                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>CHESAPEAKE MANOR</b>   |                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>                                                 |  |                                                                                      |  |                                                                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><b>BALTO</b>                                                                               |                                                                        | 13c. CITY OR TOWN<br><b>BALTO</b>                                                                                                                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>4739 OLD COURT RD.</b>                             |  |
| 14. FATHER'S NAME<br>First <b>HENRY</b> Middle <b>SCHILB</b> Last <b>WACHTER</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>Peter</b> |                                                                                                                                                             |  |                                                                                      |  |                                                                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>no</b>                                                                                                                                                                                                                                                                                                                              |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-6113 B</b>                                                          |                                                                        | 17. INFORMANT<br><b>Mr. Austin W. Widerman</b>                                                                                                              |  | Address<br><b>4739 Old Court Road</b>                                                |  |                                                                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b><br><b>1538</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Carcinoma colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebrovascular accident (stroke)</b> |  |                                                                                                           |                                                                        |                                                                                                                                                             |  |                                                                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 mths?</b><br><b>5 mths</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Cerebrovascular accident (stroke)</b>                                                                                                                                                                                                                                                  |  |                                                                                                           |                                                                        |                                                                                                                                                             |  |                                                                                      |  |                                                                                 |  |
| 19a. DATE OF OPERATION<br><b>10/2/68</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma bowel</b>                                |                                                                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |                                                                                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. <b>1</b> Month <b>10</b> Day <b>2</b> Year <b>1968</b><br>P.M. <b>19</b> |                                                                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                      |  |                                                                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |                                                                        | 21f. LOCATION Street or R.F.D. No. <b>1/6</b> City or Town <b>1965</b> County <b>219</b> State <b>1969</b>                                                  |  |                                                                                      |  |                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> , 19 <b>65</b> , to <b>2/9</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>2/9</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                 |  |                                                                                                           |                                                                        |                                                                                                                                                             |  |                                                                                      |  |                                                                                 |  |
| 22b. SIGNATURE<br><b>Manuel Feldman MD</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                        | DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |  | 22c. DATE/SIGNATURE<br><b>2/9/69</b>                                                 |  |                                                                                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Manuel Feldman</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                           |                                                                        | 22e. ADDRESS<br><b>6610 Cran County Blvd</b>                                                                                                                |  |                                                                                      |  |                                                                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 23b. DATE<br><b>Feb. 12, 69</b>                                                                           |                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>                                                                                             |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown Balto. Md.</b>      |  |                                                                                 |  |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers Chapel 8728 Liberty Road 21133</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                           |                                                                        | ADDRESS<br><b>8728 Liberty Road 21133</b>                                                                                                                   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1969</b>                                        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |  |

02176

02176

W. A. ... 1923

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02177

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02172

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                      |                                                                       |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                                                  |                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br><b>VIVIAN L. WIEDEROCK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                      | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>FEB 16 1969</b>       |                                                                                                                                                             |                                                                                                             | 2b. HOUR<br>M<br><b>M</b>                                                                       |                                                                                     |                                                                  |                           |
| 3. SEX<br><b>F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>JAN 5 1921</b>                                                                | 6. AGE (in years lost birthday)<br><b>48 YRS.</b>                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                                                                    |                                                                                                             | IF UNDER 24 HRS<br>HOURS MIN                                                                    |                                                                                     | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>FEB 16 1969</b> | 2d. HOUR<br>M<br><b>M</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                           |                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                             | 9. COUNTY OF DEATH<br><b>BALTO.</b>                                                             |                                                                                     |                                                                  | Md.                       |
| 10. CITY OR TOWN OF DEATH<br><b>ESSEX</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7602 GOUGH ST</b> |                                                                       |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                   |                                                                  |                           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | 13b. COUNTY<br><b>BALTO</b>                                                                          |                                                                       | 13c. CITY OR TOWN<br><b>ESSEX</b>                                                                                                                           |                                                                                                             | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                     | 13e. STREET AND NUMBER<br><b>7602 GOUGH ST</b>                   |                           |
| 14. FATHER'S NAME<br>First Middle Last<br><b>CHARLES POOLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                                      | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>OLIVE MAUGANS</b> |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                                                  |                           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>UNK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)                                   |                                                                       | 17. INFORMANT<br><b>GEORGE WIEDEROCK</b>                                                                                                                    |                                                                                                             |                                                                                                 | ADDRESS<br><b>ABOVE</b>                                                             |                                                                  |                           |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                                                                  |                     |                                                                                                      |                                                                       |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                      |                                                                       |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                                                  |                           |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |                                                                                                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |                                                                                                                                                             |                                                                                                             |                                                                                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                  |                           |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |                                                                                                      | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>      |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |                                                                                                 |                                                                                     |                                                                  |                           |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |                                                                       | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                                                                                             | City or Town                                                                                    |                                                                                     | County                                                           | State                     |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |                     |                                                                                                      |                                                                       |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                                                  |                           |
| ACTUAL SIGNATURE<br><b>THEO C. PATTERSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |                                                                                                      | M.D.                                                                  |                                                                                                                                                             |                                                                                                             | 22b. DATE SIGNED<br><b>2/18/69</b>                                                              |                                                                                     |                                                                  |                           |
| EXAMINER'S NAME (Type)<br><b>THEO C. PATTERSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |                                                                                                      | ADDRESS<br><b>300</b>                                                 |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                                                  |                           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | 23b. DATE<br><b>2/19/69</b>                                                                          |                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN</b>                                                                                                       |                                                                                                             | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                              |                                                                                     |                                                                  |                           |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                                                      | ADDRESS<br><b>300</b>                                                 |                                                                                                                                                             |                                                                                                             | 25a. REC'D BY REGISTRAR<br><b>MACT</b>                                                          |                                                                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     |                                                                                                      | DATE<br><b>FEB 20 1969</b>                                            |                                                                                                                                                             |                                                                                                             |                                                                                                 |                                                                                     |                                                                  |                           |



25172

ACUTE LEUKEMIA - CLINICAL OF DEATH

25172

Acute Leukemia  
Chronic Obstructive  
Disease

2/18/67

~~Heckel~~  
J.H. C. 144-6524

25172



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

02178

02174

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                                                                              |                  |                                                                                                                                                          |                                     |                                                                                              |                                |                        |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------|------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                     |         | First                                                                        | Middle           | Last                                                                                                                                                     | 2a. DATE OF DEATH<br>Month Day Year |                                                                                              | 2b. HOUR                       |                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                         |         | Williams                                                                     |                  |                                                                                                                                                          | 2 7 1969                            |                                                                                              | 3 P.M.                         |                        |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. RACE |                                                                              | 5. DATE OF BIRTH |                                                                                                                                                          | 6. AGE (In years lost birthday)     |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS |                        |  |
| Male                                                                                                                                                                                                                                                                                                                                                                                                                    | White   |                                                                              | February 7, 1969 |                                                                                                                                                          | YRS.                                |                                                                                              | IF UNDER 24 HRS.<br>HOURS MIN  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                               |         | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH                                                                           |                                |                        |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |         | U.S.A.                                                                       |                  |                                                                                                                                                          |                                     | Baltimore, Md.                                                                               |                                |                        |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                               |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                  |                                     | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                |                        |  |
| Towson                                                                                                                                                                                                                                                                                                                                                                                                                  |         | St. Joseph Hospital                                                          |                  | N/A                                                                                                                                                      |                                     |                                                                                              |                                |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                           |         | 13b. COUNTY                                                                  |                  | 13c. CITY OR TOWN                                                                                                                                        |                                     | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET AND NUMBER |  |
| Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |         | Baltimore                                                                    |                  | Baltimore                                                                                                                                                |                                     |                                                                                              |                                | 8545 Pulaski Highway   |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                       |         | 15. MOTHER'S MAIDEN NAME                                                     |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)                                                                       |                                     | 16b. SOCIAL SECURITY NO.                                                                     |                                | 17. INFORMANT Address  |  |
| James Edward Williams                                                                                                                                                                                                                                                                                                                                                                                                   |         | Cora Sue Ray                                                                 |                  |                                                                                                                                                          |                                     |                                                                                              |                                |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u><br><u>740X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |         |                                                                              |                  |                                                                                                                                                          |                                     |                                                                                              |                                |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                      |         |                                                                              |                  |                                                                                                                                                          |                                     |                                                                                              |                                |                        |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                      |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                     |                                                                                              |                                |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                            |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                     |                                                                                              |                                |                        |  |
| 22a. I certify that (this hospital) attended the deceased from <u>2/7/</u> , 19 <u>69</u> , to <u>2/7/</u> , 19 <u>69</u> , that (we) last saw the deceased alive on <u>2/7/</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                                              |         |                                                                              |                  |                                                                                                                                                          |                                     |                                                                                              |                                |                        |  |
| 22b. SIGNATURE<br><u>Chris L. Williams, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                        |         | 22c. DATE SIGNED<br><u>2/7/69</u>                                            |                  | 22d. PHYSICIAN'S NAME (Type) <u>CHRISTINA A. WILLIAMS, M.D.</u>                                                                                          |                                     |                                                                                              |                                |                        |  |
| 22e. ADDRESS<br><u>7620 York Rd., Towson, Md. 21204</u>                                                                                                                                                                                                                                                                                                                                                                 |         |                                                                              |                  |                                                                                                                                                          |                                     |                                                                                              |                                |                        |  |
| 23a. BURIAL (CREMATION) REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                               |         | 23b. DATE<br><u>2-12-69</u>                                                  |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Joseph Med. School</u>                                                                                      |                                     | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                       |                                |                        |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                    |         | 25a. RECEIVED BY REGISTRAR<br>DATE<br><u>FEB 14 1969</u>                     |                  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                         |                                     |                                                                                              |                                |                        |  |

4180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

| <div>Item 18 Fill 410 3-12-69</div> <div>02179</div> <div>02175</div>                                                                                                                                                                                                                                                 |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|----------------------------------------------|--|
| <div>1. DECEASED-NAME (Type or print)</div> <div>CALEB E. WILLIAMS</div>                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| <div>20. DATE OF DEATH</div> <div>Month 2- Day 21- Year 69</div> <div>2b. HOUR 5:47 P.M.</div>                                                                                                                                                                                                                        |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (In years lost birthday)                                      |  | 7. COUNTY OF DEATH                                                                           |  | 8. IF UNDER 1 YEAR                                                           |                                              |  |
| MALE                                                                                                                                                                                                                                                                                                                  |  | WHITE                                                                        |  | 1869                                                                                                                                                     |  | 99                                                                   |  | BALTIMORE                                                                                    |  | MONTHS DAYS HOURS MIN                                                        |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                             |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                   |  | 10. CITY OR TOWN OF DEATH                                                                    |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                              |  |
| Pennsylvania                                                                                                                                                                                                                                                                                                          |  | U.S.A.                                                                       |  |                                                                                                                                                          |  | BALTIMORE                                                            |  | Towson, Maryland                                                                             |  | St. Joseph's Hospital                                                        |                                              |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                                                                                                                                                                                                                               |  | 12b. KIND OF BUSINESS OR INDUSTRY                                            |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                            |  | 13b. CITY OR TOWN                                                    |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET AND NUMBER                                                       |                                              |  |
| Laborer                                                                                                                                                                                                                                                                                                               |  | Slate Quarry                                                                 |  | Maryland                                                                                                                                                 |  | Baltimore                                                            |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 3521 Hiss Avenue, 21234                                                      |                                              |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                     |  | 15. MOTHER'S MAIDEN NAME                                                     |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)                                                                       |  | 16b. SOCIAL SECURITY NO.                                             |  | 17. INFORMANT                                                                                |  | Address                                                                      |                                              |  |
| David Williams                                                                                                                                                                                                                                                                                                        |  | Mary Hutton                                                                  |  | No                                                                                                                                                       |  | 216-24-4805                                                          |  | A Mrs. Harry Hamilton                                                                        |  | Covington, Ky.                                                               |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                             |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Septicemia</u></div> <div>038.9</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.</div> <div>(b) <u>Organism not known</u></div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                   |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                                                                              |  |                                                                              |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                    |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-16-1969, to 2-21-1969, that (I) (we) last saw the deceased alive on 2-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.          |  |                                                                              |  |                                                                                                                                                          |  |                                                                      |  |                                                                                              |  |                                                                              |                                              |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                        |  | 22c. PHYSICIAN'S NAME (Type)                                                 |  | 22d. ADDRESS                                                                                                                                             |  | 22e. DATE SIGNED                                                     |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |                                                                              |                                              |  |
| <i>Christinna Feliciano, M.D.</i>                                                                                                                                                                                                                                                                                     |  | Christinna Feliciano, M. D.                                                  |  | 7620 York Road, Towson, Md. 21204                                                                                                                        |  | 2-22-1969                                                            |  |                                                                                              |  |                                                                              |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                             |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)                        |  | 23e. FUNERAL DIRECTOR                                                                        |  |                                                                              |                                              |  |
| Burial                                                                                                                                                                                                                                                                                                                |  | Feb. 24, 1969                                                                |  | Slate Ridge Cemetery                                                                                                                                     |  | Delta, York Co., Pa.                                                 |  | John H. Harkins                                                                              |  |                                                                              |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                  |  | ADDRESS                                                                      |  | 25a. REC'D BY REGISTRAR                                                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE                                           |  | DATE                                                                                         |  |                                                                              |                                              |  |
| John H. Harkins                                                                                                                                                                                                                                                                                                       |  | Delta, Pa.                                                                   |  | FEB 25 1969                                                                                                                                              |  | <i>Charles Judge</i>                                                 |  |                                                                                              |  |                                                                              |                                              |  |

02150

0350 0400 0450

07100

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

000 2 000

000 2 000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02180

02176

|                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                            |                                                                               |                                                                                                                                                             |  |                                                                                                |  |                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ROBERT</b> First <b>WILLIAMSON</b> Middle <b>L</b> Last                                                                                                                                                                                                                                                                         |  |                                                                                                            | 2a. DATE OF DEATH<br>Month <b>Feb</b> Day <b>10</b> Year <b>1969</b>          |                                                                                                                                                             |  | 2b. HOUR<br><b>6:30</b> AM                                                                     |  |                                                                     |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br><b>White</b>                                                                                    |                                                                               | 5. DATE OF BIRTH<br><b>Aug 21, 1883</b>                                                                                                                     |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.                                              |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>md</b>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                 |                                                                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                     |  |                                                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                          |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Summit Nursing Home</b> |                                                                               | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Carpenter</b>                                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Boarding</b>                                           |  |                                                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md</b>                                                                                                                                                                                                                                                             |  | 13b. COUNTY<br><b>Baltimore</b>                                                                            |                                                                               | 13c. CITY OR TOWN<br><b>Charmers</b>                                                                                                                        |  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>5503 W North Ave</b>                   |  |
| 14. FATHER'S NAME First <b>William</b> Middle <b>Williamson</b> Last <b>W</b>                                                                                                                                                                                                                                                                                          |  |                                                                                                            | 15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>W</b> Last <b>W</b> |                                                                                                                                                             |  |                                                                                                |  |                                                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)                                                                                                                                                                                                                                                  |  | 16b. SOCIAL SECURITY NO.<br><b>216-093690</b>                                                              |                                                                               | 17. INFORMANT<br><b>Chatt</b>                                                                                                                               |  | Address <b>W</b>                                                                               |  |                                                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b><br><b>4124</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UNKNOWN</b>                                                   |  |                                                                                                            |                                                                               |                                                                                                                                                             |  |                                                                                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hrs</b>        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>BLEEDING GI TRACT</b>                                                                                                                                                                                                         |  |                                                                                                            |                                                                               |                                                                                                                                                             |  |                                                                                                |  |                                                                     |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                 |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                           |                                                                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                           |  |                                                                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                               |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                          |                                                                               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                                                             |  |                                                                                                |  |                                                                     |  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |                                                                               | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                                |  |                                                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20/65</b> , 19 <b>65</b> , to <b>2/10</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>65</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                                                            |                                                                               |                                                                                                                                                             |  |                                                                                                |  |                                                                     |  |
| 22b. SIGNATURE<br><b>Cliff Ratliff Jr.</b>                                                                                                                                                                                                                                                                                                                             |  | DEGREE <b>MD</b>                                                                                           |                                                                               | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>2/10/69</b>                                                             |  |                                                                     |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>CLIFF RATLIFE JR.</b>                                                                                                                                                                                                                                                                                                               |  | 22e. ADDRESS<br><b>4605 E. MONROE AVE</b>                                                                  |                                                                               |                                                                                                                                                             |  |                                                                                                |  |                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br><b>Feb 13 1969</b>                                                                            |                                                                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                                                                                                  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn Md</b>                            |  |                                                                     |  |
| 24. FUNERAL DIRECTOR<br><b>Howard Strong</b>                                                                                                                                                                                                                                                                                                                           |  | ADDRESS<br><b>307 W North Ave</b>                                                                          |                                                                               | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1969</b>                                                                                                               |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                             |  |                                                                     |  |

08170

CERTIFICATE OF DEATH

08170



FEB 17 1963



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 6110  
3/7/69 kk

02181

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02177

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  |                                                                                                                                                                                                                  |                                                                                                                                                             |                                                                                                         |                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br>MARIE A. WILLIG                                                                                                                                                                                                                                                                                                                                                               |                  |                                                                                                                                                                                                                  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/><br>Month Day Year<br>19                                                       |                                                                                                         | 2b. HOUR<br>M                                                                       |
| 3. SEX<br>female                                                                                                                                                                                                                                                                                                                                                                                                                          | 4. RACE<br>white | 5. DATE OF BIRTH<br>3-19-1887                                                                                                                                                                                    | 6. AGE (In years<br>last birthday)<br>81.82 YRS.                                                                                                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                                                                | IF UNDER 24 HRS.                                                                    |
| 7a. BIRTHPLACE (State or foreign<br>country) Balto. Co.                                                                                                                                                                                                                                                                                                                                                                                   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                         | 9. COUNTY OF DEATH<br>Baltimore Md.                                                 |
| 10. CITY OR TOWN OF DEATH<br>Fullerton                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Box 313 -Schroeder Ave                                                                                                        |                                                                                                                                                             | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Housewife                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                              |                  | 13b. COUNTY<br>Baltimore                                                                                                                                                                                         | 13c. CITY OR TOWN<br>Fullerton                                                                                                                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 13e. STREET AND NUMBER<br>Box 313 Schoeder Lane                                     |
| 14. FATHER'S NAME<br>First Middle Last<br>August Eisner                                                                                                                                                                                                                                                                                                                                                                                   |                  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth Schwartz                                                                                                                                              |                                                                                                                                                             | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No                                |                                                                                     |
| 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>None                                                                                                                                                                                                                                                                                                                                                                 |                  | 17. INFORMANT<br>Mrs Marten Willig Box 113 Schroeder Ave                                                                                                                                                         |                                                                                                                                                             |                                                                                                         |                                                                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.                                                   |                  |                                                                                                                                                                                                                  |                                                                                                                                                             |                                                                                                         | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                       |                  |                                                                                                                                                                                                                  |                                                                                                                                                             |                                                                                                         |                                                                                     |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                    |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                                                                                                                                                             |                                                                                                                                                             |                                                                                                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                    |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                                                                                                                                                        |                                                                                                                                                             | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |                                                                                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                                                                                                                                                                                                                                                                                                                              |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                                                                                                                                  |                                                                                                                                                             | 21f. LOCATION Street or R.F.D. No. City or Town County State                                            |                                                                                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |                                                                                                                                                                                                                  |                                                                                                                                                             |                                                                                                         |                                                                                     |
| ACTUAL<br>SIGNATURE<br>Werner U. Spitz, M.D.                                                                                                                                                                                                                                                                                                                                                                                              |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |                                                                                                                                                             | 22b. DATE SIGNED<br>2/18/69                                                                             |                                                                                     |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                    |                  | 23b. DATE<br>2-18-1969                                                                                                                                                                                           |                                                                                                                                                             | 23c. NAME OF CEMETERY OR CREMATORY<br>Perry Hall Meth Cemetery                                          |                                                                                     |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401                                                                                                                                                                                                                                                                                                                                                                                         |                  | 23d. LOCATION (City or Town) (County) (State)<br>Perry Hall Balto. md                                                                                                                                            |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br>FEB 24 1969                                                                  |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                           |                  | 25b. REGISTRAR'S SIGNATURE<br>Werner U. Spitz                                                                                                                                                                    |                                                                                                                                                             |                                                                                                         |                                                                                     |

FOR STATE  
HEALTH OFFICE

02181

AMERICAN EXAMINER'S CERTIFICATE OF DEATH

02181

|                    |  |                       |  |                       |  |                        |  |                      |  |                        |  |
|--------------------|--|-----------------------|--|-----------------------|--|------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased   |  | Age                   |  | Sex                   |  | Race                   |  | Date of Death        |  | Place of Death         |  |
| John Doe           |  | 45                    |  | Male                  |  | White                  |  | 1945-10-15           |  | New York City          |  |
| Cause of Death     |  | Disease               |  | Injury                |  | Poison                 |  | Other                |  | Manner of Death        |  |
| Heart Disease      |  | Myocardial Infarction |  |                       |  |                        |  |                      |  | Natural                |  |
| Contributing Cause |  | Hypertension          |  |                       |  |                        |  |                      |  | Immediate Cause        |  |
| Time of Death      |  | Place of Death        |  | Signature of Examiner |  | Signature of Physician |  | Signature of Coroner |  | Signature of Registrar |  |
| 10:30 AM           |  | Home                  |  | [Signature]           |  | [Signature]            |  | [Signature]          |  | [Signature]            |  |
| Date of Report     |  | Place of Report       |  | Signature of Reporter |  | Signature of Physician |  | Signature of Coroner |  | Signature of Registrar |  |
| 1945-10-16         |  | New York City         |  | [Signature]           |  | [Signature]            |  | [Signature]          |  | [Signature]            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                          |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                  |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                         |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                          |  |                                                                              | First Middle Last        |                                                                                                                                                          |                                                                     | 2a. DATE OF DEATH                                                                       |                                                                                                                                 |                                                                                              | 2b. HOUR                                     |
| Adolph                                                                                                                                                                                                                                                                                                       |  |                                                                              | Wohlmuth                 |                                                                                                                                                          |                                                                     | Month 2 Day 5 Year 69                                                                   |                                                                                                                                 |                                                                                              | 10a M                                        |
| 3. SEX                                                                                                                                                                                                                                                                                                       |  | 4. RACE                                                                      |                          | 5. DATE OF BIRTH                                                                                                                                         |                                                                     |                                                                                         | 6. AGE (In years last birthday)                                                                                                 |                                                                                              | IF UNDER 1 YEAR<br>MONTHS DAYS               |
| MALE                                                                                                                                                                                                                                                                                                         |  | WHITE                                                                        |                          |                                                                                                                                                          |                                                                     |                                                                                         | 80 YRS.                                                                                                                         |                                                                                              | IF UNDER 24 HRS.<br>HOURS MIN                |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                    |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                     | 9. COUNTY OF DEATH                                                                      |                                                                                                                                 |                                                                                              |                                              |
| Austria                                                                                                                                                                                                                                                                                                      |  | U.S.A.                                                                       |                          |                                                                                                                                                          |                                                                     | Baltimore Md.                                                                           |                                                                                                                                 |                                                                                              |                                              |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                    |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          |                                                                                                                                                          |                                                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                                                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |                                              |
| Pikesville                                                                                                                                                                                                                                                                                                   |  | Professional House                                                           |                          |                                                                                                                                                          |                                                                     | merchant                                                                                |                                                                                                                                 | RETAIL Mens Clothing                                                                         |                                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                |  |                                                                              |                          | 13b. COUNTY                                                                                                                                              |                                                                     | 13c. CITY OR TOWN                                                                       |                                                                                                                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                              |
| Maryland                                                                                                                                                                                                                                                                                                     |  |                                                                              |                          | -                                                                                                                                                        |                                                                     | Baltimore                                                                               |                                                                                                                                 | Emerson Hotel                                                                                |                                              |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                            |  |                                                                              | 15. MOTHER'S MAIDEN NAME |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| First Middle Last                                                                                                                                                                                                                                                                                            |  |                                                                              | First Middle Last        |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| Wilhelm - Wohlmuth                                                                                                                                                                                                                                                                                           |  |                                                                              | Rosa - Bledy             |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                             |  |                                                                              | 16b. SOCIAL SECURITY NO. |                                                                                                                                                          | 17. INFORMANT                                                       |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| NO                                                                                                                                                                                                                                                                                                           |  |                                                                              | 219-32-3265              |                                                                                                                                                          | MRS. OTTO WOHLMUTH, 6414 PARK HGHTS. AVE.                           |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                    |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic ca colon & hepatic failure                                                                                                                                                                                                                       |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              | 1 yr                                         |
| 1538 DUE TO, OR AS A CONSEQUENCE OF (b) Ca. Colon                                                                                                                                                                                                                                                            |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              | 3 yrs.                                       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)                                                                                                                                                                            |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                           |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| ASHD                                                                                                                                                                                                                                                                                                         |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |                                                                                                                                                          | 20a. AUTOPSY?                                                       |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                            |                                                                                              |                                              |
| 5/5/66                                                                                                                                                                                                                                                                                                       |  | Colon                                                                        |                          |                                                                                                                                                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                           |  | 21b. TIME OF INJURY                                                          |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
|                                                                                                                                                                                                                                                                                                              |  | HOUR A.M. Month Day Year P.M. 19                                             |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work                                                                                                                                                                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
|                                                                                                                                                                                                                                                                                                              |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 22a. I certify that (I) (this hospital) attended the deceased from 211, 1969, to 215, 1969, that (I) (we) last saw the deceased alive on 213, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                               |  |                                                                              |                          |                                                                                                                                                          | DEGREE                                                              |                                                                                         | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                                                                              | 22c. DATE SIGNED                             |
| Stanley M. Rosen M.D.                                                                                                                                                                                                                                                                                        |  |                                                                              |                          |                                                                                                                                                          |                                                                     |                                                                                         |                                                                                                                                 |                                                                                              | 2/5/69                                       |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                 |  |                                                                              |                          |                                                                                                                                                          | 22e. ADDRESS                                                        |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| Stanley M. Rosen, M.D.                                                                                                                                                                                                                                                                                       |  |                                                                              |                          |                                                                                                                                                          | 4000 W. Northern Parkway 21215                                      |                                                                                         |                                                                                                                                 |                                                                                              |                                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                    |  | 23b. DATE                                                                    |                          | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                     | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                                                                                 |                                                                                              |                                              |
| BURIAL                                                                                                                                                                                                                                                                                                       |  | 2-7-69                                                                       |                          | HEBREW FRIENDSHIP                                                                                                                                        |                                                                     | BALTIMORE, MARYLAND                                                                     |                                                                                                                                 |                                                                                              |                                              |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                         |  |                                                                              |                          |                                                                                                                                                          | 25a. REC'D BY REGISTRAR                                             |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                                                                                      |                                                                                              |                                              |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD                                                                                                                                                                                                                                                                 |  |                                                                              |                          |                                                                                                                                                          | FEB 11 1969                                                         |                                                                                         |                                                                                                                                 |                                                                                              |                                              |

06

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02183

02179

|                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                    |  |                                                                                                          |                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>James C. Wolfe</b>                                                                                                                                                                                                                                                                                                                                               |  | First <b>James</b> Middle <b>C.</b> Last <b>Wolfe</b>                                                                                              |  | 2a. DATE OF DEATH<br>Month <b>Feb</b> Day <b>9</b> Year <b>1969</b> 6:55 a.m.                            |                                                                                  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 4. RACE<br><b>White</b>                                                                                                                            |  | 5. DATE OF BIRTH<br><b>May 18, 1875</b>                                                                  |                                                                                  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Va.</b>                                                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                         |  | 6. AGE (In years less birthday)<br><b>93</b> YRS.                                                        |                                                                                  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                                |  | 9. COUNTY OF DEATH<br><b>Balto. Co.</b>                                                                                                            |  |                                                                                                          |                                                                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Millers</b>                                                                                                                                                                                                                                                                                                                                                             |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rd.</b>                                                         |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farmer</b> |                                                                                  |
| 12b. KIND OF BUSINESS OR INDUSTRY                                                                                                                                                                                                                                                                                                                                                                       |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>                                           |  |                                                                                                          |                                                                                  |
| 13b. COUNTY<br><b>Balto.</b>                                                                                                                                                                                                                                                                                                                                                                            |  | 13c. CITY OR TOWN<br><b>Millers</b>                                                                                                                |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                                                                  |
| 13e. STREET AND NUMBER<br><b>RD.</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 14. FATHER'S NAME First <b>Zeno</b> Middle <b>Wolfe</b> Last <b></b>                                                                               |  |                                                                                                          |                                                                                  |
| 15. MOTHER'S MAIDEN NAME First <b>Nancey</b> Middle <b>Hatfield</b> Last <b></b>                                                                                                                                                                                                                                                                                                                        |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or ar (own) <b>no</b> (If yes give war or dates of service)                                  |  |                                                                                                          |                                                                                  |
| 16b. SOCIAL SECURITY NO.<br><b>218-10-7113</b>                                                                                                                                                                                                                                                                                                                                                          |  | 17. INFORMANT Address<br><b>Mrs. J.H. Dotson RD. Millers, Md.</b>                                                                                  |  |                                                                                                          |                                                                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                                                                                                                                                    |  |                                                                                                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b><br><b>3 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |                                                                                                          |                                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |                                                                                  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                                    |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |  |                                                                                                          |                                                                                  |
| 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                                                                                                                                                                                                                                                                                                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                    |  |                                                                                                          |                                                                                  |
| 21d. INJURY OCCURRED<br>White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                             |                                                                                  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 30</b> , 19 <b>61</b> , to <b>Feb 9</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Feb 1</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.                                   |  |                                                                                                                                                    |  |                                                                                                          |                                                                                  |
| 22b. SIGNATURE<br><b>M. C. Porterfield</b>                                                                                                                                                                                                                                                                                                                                                              |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             |  | 22c. DATE SIGNED<br><b>2-10-69</b>                                                                       |                                                                                  |
| 22d. PHYSICIAN'S NAME (Type) <b>M. C. Porterfield, M.D.</b>                                                                                                                                                                                                                                                                                                                                             |  | 22e. ADDRESS<br><b>Hampstead, Md.</b>                                                                                                              |  |                                                                                                          |                                                                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>Feb. 12, 1969</b>                                                                                                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul's Cemetery</b>                                         |                                                                                  |
| 23d. LOCATION (City or Town)<br><b>Millers Md.</b>                                                                                                                                                                                                                                                                                                                                                      |  | (County) (State)                                                                                                                                   |  |                                                                                                          |                                                                                  |
| 24. FUNERAL DIRECTOR<br><b>Tipton - Eline Funeral Home</b>                                                                                                                                                                                                                                                                                                                                              |  | ADDRESS<br><b>Hampstead, Md.</b>                                                                                                                   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1969</b>                                                       |                                                                                  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Jones</b>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                    |  |                                                                                                          |                                                                                  |

05150

05150

05150

05150

05150

05150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02184

02180

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                              |                                                                                                        |                                                                                                                                                             |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------|--|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                              | First                                                                                                  | Middle                                                                                                                                                      | Last                          | 2a. DATE OF DEATH<br>Month Day Year                                                                      |                                                                                      |                                                                      | 2b. HOUR<br>M                                 |  |                                |  |
| WILLIAM H. WOLLETT, SR.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |                                                                                                        |                                                                                                                                                             |                               | Feb. 10, 1969                                                                                            |                                                                                      |                                                                      |                                               |  |                                |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 4. RACE<br>Cau.                                                              |                                                                                                        | 5. DATE OF BIRTH<br>February 26, 1902                                                                                                                       |                               |                                                                                                          | 6. AGE (In years<br>last birthday)<br>66 YRS.                                        |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS                |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |                                                                                                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               |                                                                                                          | 9. COUNTY OF DEATH<br>Baltimore Md.                                                  |                                                                      |                                               |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Timonium 21093                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>1807 Charmuth Garth |                                                                                                                                                             |                               | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Tool Maker |                                                                                      |                                                                      | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Steel |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | 13b. COUNTY<br>Baltimore                                                                               |                                                                                                                                                             | 13c. CITY OR TOWN<br>Timonium |                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER<br>1807 Charmuth Garth |  |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Sackville Wollett                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Hester G. Boone                                       |                                                                                                                                                             |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No                                                                                                                                                                                                                                                                                                                                                                |  |                                                                              | 16b. SOCIAL SECURITY NO.<br>212-10-7314                                                                |                                                                                                                                                             |                               | 17. INFORMANT<br>Address<br>Margaret S. Wollett, Same as # 13                                            |                                                                                      |                                                                      |                                               |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Infarction</u><br><u>4109</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Instant</u> |  |                                                                              |                                                                                                        |                                                                                                                                                             |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                        |                                                                                                                                                             |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                        |                                                                                                                                                             |                               | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |                                                                                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                               |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                        |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                                                             |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                        | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 13, 1965</u> , to <u>2-10, 1969</u> , that (I) (we) last saw the deceased alive on <u>Dec 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                     |  |                                                                              |                                                                                                        |                                                                                                                                                             |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| 22b. SIGNATURE<br><u>Kerth H. Ramsey</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                                                                                                                                                                                                                                                                                            |  |                                                                              |                                                                                                        |                                                                                                                                                             |                               |                                                                                                          |                                                                                      | 22c. DATE SIGNED<br><u>2-11-69</u>                                   |                                               |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              |                                                                                                        | 22e. ADDRESS                                                                                                                                                |                               |                                                                                                          |                                                                                      |                                                                      |                                               |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 23b. DATE<br>2-13-1969                                                       |                                                                                                        | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                  |                               |                                                                                                          | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                 |                                                                      |                                               |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road<br>Towson, Maryland 21204                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |                                                                                                        | ADDRESS                                                                                                                                                     |                               | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1969                                                              |                                                                                      | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>                |                                               |  |                                |  |

02180

COMMITTEE OF DEATH

02180

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

UNITED STATES OF AMERICA

THE COURT OF APPEALS

IN RE: [Name]

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

UNITED STATES OF AMERICA

U.S. DEPARTMENT OF JUSTICE

UNITED STATES OF AMERICA

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02185                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                            |  |                                |  |  |                                  |  |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------|--|--|----------------------------------|--|--|--|--|
| Item 23 Film 409 2/19/69 kk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 | CERTIFICATE OF DEATH                                                                                                                   |  |                                |  |  |                                  |  |  |  |  |
| 02181                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |                                                                                                      |  | First Middle Last<br>Alvert (Alvert) Vernon WOOD                 |                                                                                                                                                             |  |  |                                                                                                 | 2a. DATE OF DEATH<br>Month 2 Day 7 Year 69                                                                                             |  |                                |  |  | 2b. HOUR<br>7:02 A.M.            |  |  |  |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  | 4. RACE<br>White                                                                                     |  |                                                                  | 5. DATE OF BIRTH<br>June 6, 1914                                                                                                                            |  |  | 6. AGE (In years last birthday)<br>54 YRS.                                                      |                                                                                                                                        |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                               |  |                                                                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.                                                             |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Rosewood State Hosp. |  |                                                                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>none                                                             |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                               |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  | 13b. COUNTY<br>Anne Arundel                                                                          |  |                                                                  | 13c. CITY OR TOWN<br>Deale                                                                                                                                  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                                                                                                                        |  | 13e. STREET AND NUMBER<br>---  |  |  |                                  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Samuel - WOOD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |  |                                                                                                      |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Estelle - KNOPP |                                                                                                                                                             |  |  |                                                                                                 |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>no                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                      |  | 16b. SOCIAL SECURITY NO.<br>----                                 |                                                                                                                                                             |  |  |                                                                                                 | 17. INFORMANT<br>Address<br>Rosewood Records, Owings Mills, Md. 21137                                                                  |  |                                |  |  |                                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute bronchitis bilateral 447X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Aspiration of Gastric Contents 3 Days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Drowning due to left iliac arterio 2 Months<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>10. Subarachnoid hemorrhage due to severe mental retardation 2 Months |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 Days<br>3 Days<br>2 Months<br>2 Months                                               |  |                                |  |  |                                  |  |  |  |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                     |  |                                                                  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                             |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                           |  |                                                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |  |                                                                                                 |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |                                                                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |  |                                                                                                 |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1968, to 2/7, 1969, that (I) (we) lost<br>saw the deceased alive on 2/7/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.                                                                                                                                                                                                                                 |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 22b. SIGNATURE<br>Richard A. Jones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |                                |  |  | 22c. DATE SIGNED<br>Feb. 7, 1969 |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Richard A. Jones                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 | 22e. ADDRESS<br>Rosewood State Hospital                                                                                                |  |                                |  |  |                                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  | 23b. DATE<br>Feb. 9, 1969                                                                            |  |                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodfield Cemetery                                                                                                    |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Galesville A.A. Co. Md.                        |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>HARDESTY Funeral Home<br>1211 E. Bay View Ave<br>BALTIMORE, MD 21201<br>FEB 13 1969                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |                                                                                                      |  |                                                                  |                                                                                                                                                             |  |  |                                                                                                 |                                                                                                                                        |  |                                |  |  |                                  |  |  |  |  |

02181

00:00

M

1

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                        |  |                                                                                 |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------|--|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                                                                                        |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                        |  |                                                                                 |  |                                              |  |
| 02186                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                 |  |                                                                                                                                                             |  | 02182                                                                                                  |  |                                                                                 |  |                                              |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Baby (ERIN) Girl (K.) Wood</b>                                                                                                                                                                                                                                                                            |  |                                                                                                                 |  |                                                                                                                                                             |  | 2a. DATE OF DEATH Month Day Year<br><b>2 20 69</b>                                                     |  |                                                                                 |  | 2b. HOUR<br><b>5:15<sup>am</sup></b>         |  |
| 3. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><b>Cauc.</b>                                                                                         |  | 5. DATE OF BIRTH<br><b>2/19/69</b>                                                                                                                          |  | 6. AGE (In years lost birthday) YRS. MONTHS DAYS<br><b>21 30</b>                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                  |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                             |  |                                                                                 |  |                                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto Med Center</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>NONE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                               |  |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>BALTO.</b>                                                                                    |  | 13c. CITY OR TOWN<br><b>BALTO.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 13e. STREET AND NUMBER<br><b>1632 ABERDEEN RD.</b>                              |  |                                              |  |
| 14. FATHER'S NAME First Middle Last<br><b>GEORGE P. Wood</b>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                 |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>SUNNY Decker</b>                                                                                           |  |                                                                                                        |  |                                                                                 |  |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                                                                |  |                                                                                                                 |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>                                                                                                                     |  | 17. INFORMANT<br><b>GEORGE P. Wood</b>                                                                 |  | Address<br><b>(SAME)</b>                                                        |  |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity</b><br><b>7701</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                        |  |                                                                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Abruptio placenta</b>                                                                                                                                                                                                     |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                        |  |                                                                                 |  |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> |  |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                 |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                        |  |                                                                                 |  |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                            |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                |  |                                                                                                        |  |                                                                                 |  |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/19, 1969</b> , to <b>2/20, 1969</b> , that (I) (we) last saw the deceased alive on <b>2/20, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |                                                                                                                 |  |                                                                                                                                                             |  |                                                                                                        |  |                                                                                 |  |                                              |  |
| 22b. SIGNATURE<br><b>John E. Adams, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                |  |                                                                                                                 |  |                                                                                                                                                             |  | 22c. DATE SIGNED<br><b>2/21/69</b>                                                                     |  |                                                                                 |  |                                              |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                 |  |                                                                                                                                                             |  | 22e. ADDRESS<br><b>6701 N. Charles Street</b>                                                          |  |                                                                                 |  |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                                                         |  | 23b. DATE<br><b>2/27/69</b>                                                                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEM.</b>                                                                                           |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                                     |  |                                                                                 |  |                                              |  |
| 24. FUNERAL DIRECTOR<br><b>LEONARD J. RUCK, INC. BALTO. MD.</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                 |  |                                                                                                                                                             |  | 25a. REC'D BY REGISTRAR<br><b>FEB 28 1969</b>                                                          |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |  |                                              |  |

05189

MAN 16 MAY 1971

151 11

151 11

151 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1

|                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                |                                                        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------|
| 02187<br>Bessie Belle                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                              |                                                                                                                                        | 02183                                                                          |                                                        |
| 1. DECEASED-NAME (Type or print) <u>Bessie Belle Woodward</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                                              |                                                                                                                                                          | 2a. DATE OF DEATH <u>Feb</u> <u>26</u> <u>1969</u>                                                                                     |                                                                                | 2b. HOUR <u>3:45 AM</u>                                |
| 3. SEX <u>F</u>                                                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE <u>W</u>                                                                                             | 5. DATE OF BIRTH <u>1-4-95</u>                                                                                                                           |                                                                                                                                        | 6. AGE (In years last birthday) <u>74</u> YRS.                                 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) <u>Illinois</u>                                                                                                                                                                                                                                                                                                                                                               | 7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>                                                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <u>Baltimore</u> Md.                                                                                                |                                                                                |                                                        |
| 10. CITY OR TOWN OF DEATH <u>Catonsville</u>                                                                                                                                                                                                                                                                                                                                                                            | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Spring Grove State Hosp.</u> |                                                                                                                                                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>                               | 12b. KIND OF BUSINESS OR INDUSTRY                                              |                                                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE <u>md.</u> COUNTY <u>Anne Arundel</u>                                                                                                                                                                                                                                                                                      | 13b. CITY OR TOWN <u>Brooklyn</u>                                                                            | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                             | 13e. STREET AND NUMBER <u>330 River View</u>                                                                                           |                                                                                |                                                        |
| 14. FATHER'S NAME First <u>J</u> Middle <u>W.</u> Last <u>Binkley</u>                                                                                                                                                                                                                                                                                                                                                   | 15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u>Binkley</u> Last <u>Miller</u>                         |                                                                                                                                                          |                                                                                                                                        |                                                                                |                                                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)                                                                                                                                                                                                                                                                                                        | 16b. SOCIAL SECURITY NO. <u>212-32-5694</u>                                                                  | 17. INFORMANT <u>Daughter</u> Address                                                                                                                    |                                                                                                                                        |                                                                                |                                                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br><u>2509</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                                                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Generalized Arteriosclerosis - Osteoarthritis</u>                                                                                                                                                                                                                             |                                                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                |                                                        |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |                                                        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                      | 21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u>                                                       |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                        |                                                                                |                                                        |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                 | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |                                                                                                                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                           |                                                                                |                                                        |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1967</u> , to <u>26 Feb, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                          |                                                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                |                                                        |
| 22b. SIGNATURE <u>E. Trujillo</u>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                              |                                                                                                                                                          | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED <u>Feb 26/69</u>                                              |                                                        |
| 22d. PHYSICIAN'S NAME (Type) <u>EMILIO A. TRUJILLO</u>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                              |                                                                                                                                                          | 22e. ADDRESS <u>Spring Grove State Hospital</u>                                                                                        |                                                                                |                                                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                 | 23b. DATE <u>3-1-69</u>                                                                                      | 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale Cem.</u>                                                                                                |                                                                                                                                        | 23d. LOCATION (City or Town) (County) (State) <u>Elkridge, Md. (Annapolis)</u> |                                                        |
| 24. FUNERAL DIRECTOR <u>John H. Nahn</u> ADDRESS <u>4210 Remington Ave.</u>                                                                                                                                                                                                                                                                                                                                             |                                                                                                              |                                                                                                                                                          | 25a. RECEIVED BY REGISTRAR <u>W.D.</u> DATE <u>MAR 3 1969</u>                                                                          |                                                                                | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>        |

08183

08183

RECEIVED

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                      |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                                                                                                                                                                                                              |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                      |  |                                                                              | First                                                                        | Middle                                                                                                                                                   | Last                                                                                                                                   | 20. DATE OF DEATH                                                                       |                                                                                              |                                   | 2b. HOUR                                     |  |
| Clarence                                                                                                                                                                                                                                                                                                 |  |                                                                              | Leslie                                                                       | Wright                                                                                                                                                   | 2-1-69 Day                                                                                                                             |                                                                                         |                                                                                              | Year                              | 11:55 PM                                     |  |
| 3. SEX                                                                                                                                                                                                                                                                                                   |  | 4. RACE                                                                      |                                                                              | 5. DATE OF BIRTH                                                                                                                                         |                                                                                                                                        | 6. AGE (In years last birthday)                                                         |                                                                                              | IF UNDER 1 YEAR                   |                                              |  |
| Male                                                                                                                                                                                                                                                                                                     |  | White                                                                        |                                                                              | Nov. 17, 1897                                                                                                                                            |                                                                                                                                        | 89 YRS.                                                                                 |                                                                                              | MONTHS DAYS HOURS MIN             |                                              |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |                                                                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                                                                        | 9. COUNTY OF DEATH                                                                      |                                                                                              |                                   |                                              |  |
| Havre de Grace                                                                                                                                                                                                                                                                                           |  | U.S.A.                                                                       |                                                                              |                                                                                                                                                          |                                                                                                                                        | Baltimore Md.                                                                           |                                                                                              |                                   |                                              |  |
| 10. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                                                                                                                                          |                                                                                                                                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                                                                              | 12b. KIND OF BUSINESS OR INDUSTRY |                                              |  |
| Catonsville                                                                                                                                                                                                                                                                                              |  |                                                                              | Spring Grove State Hosp.                                                     |                                                                                                                                                          |                                                                                                                                        | Caretaker                                                                               |                                                                                              | Brass, Machine                    |                                              |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE                                                                                                                                                                                                            |  |                                                                              | 13b. COUNTY                                                                  |                                                                                                                                                          | 13c. CITY OR TOWN                                                                                                                      |                                                                                         | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Maryland                                                                                                                                                                                                                                                                                                 |  |                                                                              | Baltimore                                                                    |                                                                                                                                                          | Have de Grace                                                                                                                          |                                                                                         | YES                                                                                          |                                   | 322 N. Union Ave.                            |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                        |  |                                                                              | 15. MOTHER'S MAIDEN NAME                                                     |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| First Middle Last                                                                                                                                                                                                                                                                                        |  |                                                                              | First Middle Last                                                            |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| John Wright                                                                                                                                                                                                                                                                                              |  |                                                                              | Irvin, Martha                                                                |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                                                                                                                                                                                                                                         |  |                                                                              | 16b. SOCIAL SECURITY NO.                                                     |                                                                                                                                                          | 17. INFORMANT Address                                                                                                                  |                                                                                         |                                                                                              |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                          |  |                                                                              | 218-32-2276                                                                  |                                                                                                                                                          | Spring Grove State Hospital                                                                                                            |                                                                                         |                                                                                              |                                   |                                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| IMMEDIATE CAUSE (a) Coronary Insufficiency                                                                                                                                                                                                                                                               |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| 4412 DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                      |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| (b) Arteriosclerious with Poss. Rupture of abd. aneurysm                                                                                                                                                                                                                                                 |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| DUE TO, OR AS A CONSEQUENCE OF                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| (c) Senile Condition                                                                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                      |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                              |                                                                                                                                                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                      |                                                                                         | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                       |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                                                              |                                                                                                                                                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                 |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                              |                                                                                                                                                          | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                           |                                                                                         |                                                                                              |                                   |                                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-27-1966, to 2-1-1969, that (I) (we) last saw the deceased alive on 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                                                                              |                                                                              |                                                                                                                                                          |                                                                                                                                        |                                                                                         |                                                                                              |                                   |                                              |  |
| 22b. SIGNATURE Stella Wachslar                                                                                                                                                                                                                                                                           |  |                                                                              |                                                                              |                                                                                                                                                          | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                                                                         | 22c. DATE SIGNED 2/2/69                                                                      |                                   |                                              |  |
| 22d. PHYSICIAN'S NAME (Type) Stella Wachslar                                                                                                                                                                                                                                                             |  |                                                                              |                                                                              |                                                                                                                                                          | 22e. ADDRESS                                                                                                                           |                                                                                         |                                                                                              |                                   |                                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                |  | 23b. DATE                                                                    |                                                                              | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |                                                                                                                                        | 23d. LOCATION (City or Town) (County) (State)                                           |                                                                                              |                                   |                                              |  |
|                                                                                                                                                                                                                                                                                                          |  | 2/5/69                                                                       |                                                                              | Green Hill Cem                                                                                                                                           |                                                                                                                                        | Hained Chase Heights Md                                                                 |                                                                                              |                                   |                                              |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                     |  |                                                                              |                                                                              |                                                                                                                                                          | 25a. REC'D BY REGISTRAR                                                                                                                |                                                                                         | 25b. REGISTRAR'S SIGNATURE                                                                   |                                   |                                              |  |
| James H. Hained Chase                                                                                                                                                                                                                                                                                    |  |                                                                              |                                                                              |                                                                                                                                                          | FEB 6 1969                                                                                                                             |                                                                                         | Charles Judge                                                                                |                                   |                                              |  |

02182

UNITED STATES OF AMERICA

02182

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02189

Item 23 Film 411 4/2/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02185

|                                                                                                                                                                                                                                                                                                                                                                                               |                                               |                                                                                                                                                             |                                                                           |                                                                                         |                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>IRVIN WINFIELD YEAKLE</b>                                                                                                                                                                                                                                                                                                                              |                                               |                                                                                                                                                             | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>25</b> Year <b>1969</b> |                                                                                         | 2b. HOUR<br><b>12:45 AM</b>                                 |
| 3. SEX<br><b>MALE</b>                                                                                                                                                                                                                                                                                                                                                                         | 4. RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH<br><b>2/11/96</b>                                                                                                                          |                                                                           | 6. AGE (In years last birthday)<br><b>73</b> YRS.                                       | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                |                                                                                         |                                                             |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                                                                                                                                                                                                                               |                                               | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMIN. HOSPITAL</b>                                             |                                                                           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY                           |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                               |                                               | 13b. CITY OR TOWN<br><b>WASHINGTON</b>                                                                                                                      | 13c. CITY OR TOWN<br><b>HAGERSTOWN</b>                                    | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    | 13e. STREET AND NUMBER<br><b>108 RANDOLPH AVENUE</b>        |
| 14. FATHER'S NAME First Middle Last<br><b>VICTOR D. YEAKLE</b>                                                                                                                                                                                                                                                                                                                                |                                               |                                                                                                                                                             | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ANNIE F. DEAL</b>        |                                                                                         |                                                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>YES</b>                                                                                                                                                                                                                                                                                                             |                                               | 16b. SOCIAL SECURITY NO.<br><b>217 54 9507</b>                                                                                                              |                                                                           | 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>                          |                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF URINARY BLADDER, ADVANCED</b><br><b>188X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                               |                                                                                                                                                             |                                                                           |                                                                                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                                                                                                                                                                                                                                                           |                                               |                                                                                                                                                             |                                                                           |                                                                                         |                                                             |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                        |                                               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                                                                            |                                                                           | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |                                                             |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                                                                                                                                                                                                                                                                                                          |                                               |                                                                                                                                                             |                                                                           |                                                                                         |                                                             |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                      |                                               | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                                                                                  |                                                                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)         |                                                             |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work                                                                                                                                                                                                                                                                                  |                                               | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                                                                |                                                                           | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                                             |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>JAN 13</b> , 19 <b>69</b> , to <b>FEB 25</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>FEB 25</b> , 19 <b>69</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.                       |                                               |                                                                                                                                                             |                                                                           |                                                                                         |                                                             |
| 22b. SIGNATURE<br><b>Madhav D. Barhanpurkar</b>                                                                                                                                                                                                                                                                                                                                               |                                               |                                                                                                                                                             |                                                                           | 22c. DATE SIGNED<br><b>2/25/69</b>                                                      |                                                             |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV D. BARHANPURKAR, M.D.</b>                                                                                                                                                                                                                                                                                                                           |                                               |                                                                                                                                                             |                                                                           | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>                                             |                                                             |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                              |                                               | 23b. DATE<br><b>2/27/69</b>                                                                                                                                 |                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                        |                                                             |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Hagerstown, Maryland</b>                                                                                                                                                                                                                                                                                                                  |                                               | 23e. LOCATION (City or Town) (County) (State)<br><b>Hagerstown, Maryland</b>                                                                                |                                                                           |                                                                                         |                                                             |
| 24. PHYSICIAN<br><b>W.T. NORMENT RT#5, HAGERSTOWN, MD. 21740</b>                                                                                                                                                                                                                                                                                                                              |                                               |                                                                                                                                                             | 25a. REC'D BY REGISTRAR<br><b>MAR 4 1969</b>                              |                                                                                         | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>          |



02182

02182

OFFICE OF THE

RECORDS

SECTION

UNIT

RECORDS

SECTION

UNIT

RECORDS SECTION

UNIT

RECORDS SECTION

UNIT

UNIT

UNIT

UNIT

UNIT

UNIT

RECORDS SECTION  
UNIT

UNIT

UNIT

UNIT

UNIT

UNIT

UNIT

UNIT

UNIT

UNIT

UNIT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                              |                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|--|
| 82190<br>Item 15 Film 409 2/24/69 kk                                                                                                                                                                                                                                                                                                                                       |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                  |                                                                       | DEPARTMENT OF HEALTH                                                                                                                                                                                                                                                                                                                                                                                      |  | 02186                                                                                                           |  |
| 1. DECEASED-NAME<br>(Type or print) <u>ELmer S Kingling</u>                                                                                                                                                                                                                                                                                                                |  |                                                                                                              | 2a. DATE OF DEATH<br>Month <u>FEB.</u> Day <u>14</u> Year <u>1969</u> |                                                                                                                                                                                                                                                                                                                                                                                                           |  | 2b. HOUR<br><u>1 A.M.</u>                                                                                       |  |
| 3. SEX<br><u>M</u>                                                                                                                                                                                                                                                                                                                                                         |  | 4. RACE<br><u>W</u>                                                                                          |                                                                       | 5. DATE OF BIRTH<br><u>2-2-95</u>                                                                                                                                                                                                                                                                                                                                                                         |  | 6. AGE (In years last birthday)<br><u>73</u> YRS.                                                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>BALTO.</u>                                                                                                                                                                                                                                                                                                                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                |                                                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                                                                                                                                                    |  | 9. COUNTY OF DEATH<br><u>Baltimore</u> Md.                                                                      |  |
| 10. CITY OR TOWN OF DEATH<br><u>Randallstown</u>                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>BALTO. CO. GEN. HOSP.</u> |                                                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Salesman for Brass and Copper Co.</u>                                                                                                                                                                                                                                                                       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Md.</u>                                                                                                                                                                                                                                                                |  | 13b. COUNTY<br><u>BALTO.</u>                                                                                 |                                                                       | 13c. CITY OR TOWN<br><u>Rockdale</u>                                                                                                                                                                                                                                                                                                                                                                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 13e. STREET AND NUMBER<br><u>8314 Liberty Rd.</u>                                                                                                                                                                                                                                                                                                                          |  | 14. FATHER'S NAME<br>First <u>Harry</u> Middle <u>Kingling</u> Last <u>Kingling</u>                          |                                                                       | 15. MOTHER'S MAIDEN NAME<br>First <u>MARY</u> Middle <u>Bowen</u> Last <u>Bowen</u>                                                                                                                                                                                                                                                                                                                       |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <u>NO</u> (If yes give war or dates of service) |  |
| 16a. SOCIAL SECURITY NO.<br><u>215-03-4933</u>                                                                                                                                                                                                                                                                                                                             |  | 17. INFORMANT<br><u>Hosp. Record</u>                                                                         |                                                                       | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br><u>492X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CHRONIC PULMONARY EMPHYSEMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                         |  |                                                                                                              |                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                 |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                             |                                                                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                         |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>                                            |                                                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                 |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                             |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |                                                                       | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB. 1</u> , 19 <u>69</u> , to <u>FEB. 14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>FEB. 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |                                                                                                              |                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                 |  |
| 22b. SIGNATURE<br><u>Fausto Q. Aquino Jr.</u>                                                                                                                                                                                                                                                                                                                              |  | 22c. DATE SIGNED<br><u>2-14-69</u>                                                                           |                                                                       | 22d. PHYSICIAN'S NAME (Type)<br><u>FAUSTO Q. AQUINO JR. BALTO. COUNTY GEN. HOSP.</u>                                                                                                                                                                                                                                                                                                                      |  | 22e. ADDRESS                                                                                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                 |  | 23b. DATE<br><u>Feb. 17, 69</u>                                                                              |                                                                       | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lorraine Park Cem.</u>                                                                                                                                                                                                                                                                                                                                           |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Windsor Mill Rd. Balto. Co. Md.</u>                         |  |
| 24. FUNERAL DIRECTOR<br><u>Loring Byers</u>                                                                                                                                                                                                                                                                                                                                |  | ADDRESS<br><u>8728 Liberty Rd. 21133</u>                                                                     |                                                                       | 25a. REC'D BY REGISTRAR<br><u>FEB 18 1969</u>                                                                                                                                                                                                                                                                                                                                                             |  | 25b. REGISTRAR'S SIGNATURE<br><u>H. J. ...</u>                                                                  |  |

02190

45188

73

... ..

... ..

... ..

12-00-1933

30

... ..

... ..

... ..

... ..

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02187

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|--|
| 1. DECEASED NAME<br>(Type or Print) <b>WILLIAM</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                         | First <b>P.</b>                                                                                                   |  | Middle <b>YOST</b>                                                                                                                                          |  | Last <b>YOST</b>                                                                                              |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> Month Day Year<br>FEB. 16, 1969 |                                                   | 2b. HOUR<br>5:30 P.M.                                       |  |
| 3. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                                                                                                                | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>7-17-36</b>                                                                                |  | 6. AGE (In years last birthday)<br><b>32</b> YRS.                                                                                                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                |  | IF UNDER 24 HRS<br>HOURS MIN.                                                                 |                                                   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>FEB. 16, 1969 |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                              |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.                                                                    |  |                                                                                               |                                                   |                                                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Turner Station</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7410 Old Battle Grove Road</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Maintenance</b> |  |                                                                                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b> |                                                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>                                                                                                                                                                                                                                                                                                                                        |                         | 13b. COUNTY<br><b>Balto.</b>                                                                                      |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                                                                                                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET AND NUMBER<br><b>7410 OLD Battle Grove Rd.</b>                                    |                                                   |                                                             |  |
| 14. FATHER'S NAME<br><b>William</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                         | First <b>William</b>                                                                                              |  | Middle <b>Yost</b>                                                                                                                                          |  | Last <b>Yost</b>                                                                                              |  | 15. MOTHER'S MAIDEN NAME<br><b>Virginia</b>                                                   |                                                   | First <b>Basile</b>                                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                   |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><b>-</b>                                     |  | 17. INFORMANT<br><b>Mr. William Yost</b>                                                                                                                    |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                   |  | ADDRESS<br><b>7007 Gough Street Baltimore, Md.</b>                                                                                                          |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carbon monoxide</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>9520</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                                                               |                         |                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                               |                         |                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                                                                                           |  |                                                                                                               |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                                                   |                                                             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH                                                                                                                                                                                                                                                                                                                       |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>2/17/69</b> P.M. <b>Unk.</b> 19                                        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Asphyxiated</b>                                                       |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                    |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Garage</b>                     |  | 21f. LOCATION Street or R.F.D. No.<br><b>7410 Old Battle Grove Rd.</b>                                                                                      |  |                                                                                                               |  | City or Town<br><b>Balto.</b>                                                                 |                                                   | State<br><b>M.D.</b>                                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |                                                                                                                   |  |                                                                                                                                                             |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                         | EXAMINER'S NAME (Type)<br><b>Ronald N. Kornblum, M.D.</b>                                                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                             |  |                                                                                                               |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                                |                                                   |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                                                                                            |  |                                                                                                               |  | 22b. DATE SIGNED<br><b>2/17/69</b>                                                            |                                                   |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                         |                                                                                                                   |  | ADDRESS (Street, city, town, or county)                                                                                                                     |  |                                                                                                               |  |                                                                                               |                                                   |                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                           |                         | 23b. DATE<br><b>2-19-69</b>                                                                                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                                                                              |  |                                                                                                               |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                        |                                                   |                                                             |  |
| 24. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews</b>                                                                                                                                                                                                                                                                                                                                                                                                  |                         |                                                                                                                   |  | ADDRESS<br><b>3021 Eastern Ave., Baltimore, Md.</b>                                                                                                         |  |                                                                                                               |  | 25a. REC'D BY REGISTRAR<br><b>FEB 19 1969</b>                                                 |                                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judice</b>         |  |

5220

— H. W. G. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 13, 14 & 15 filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02188

|                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 |                                                                      |                                                    |       |                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------|-------|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                          |  | First<br>Robert E.                                                           |                                                                                                     | Middle<br>Lee                                                                                                                                               |                                | Last<br>Young                                                                                            |                                                                                                 | 2a. DATE OF DEATH<br>Month<br>February Day<br>24, Year<br>1969       |                                                    |       | 2b. HOUR<br>P.<br>1:05 M.      |  |
| 3. SEX<br>Male                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 4. RACE<br>White                                                             |                                                                                                     | 5. DATE OF BIRTH<br>9-21-1883                                                                                                                               |                                |                                                                                                          | 6. AGE in years<br>lost (day)<br>85 YRS.                                                        |                                                                      | IF UNDER 1 YEAR<br>MONTHS DAYS                     |       | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Carroll Co.                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |                                                                                                     | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH<br>Baltimore                                                                          |                                                                                                 |                                                                      | Md.                                                |       |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Towson                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |                                                                                                                                                             |                                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Self-employed |                                                                                                 |                                                                      | 12b. KIND OF BUSINESS OR INDUSTRY                  |       |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                    |  |                                                                              | 13b. COUNTY<br>Baltimore                                                                            |                                                                                                                                                             | 13c. CITY OR TOWN<br>Baltimore |                                                                                                          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                      | 13e. STREET AND NUMBER<br>4408 Bayonne Ave. #21206 |       |                                |  |
| 14. FATHER'S NAME<br>First<br>Elisha Middle<br>S. Last<br>Young                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              | 15. MOTHER'S MAIDEN NAME<br>First<br>Matilda A. Middle<br>A. Last<br>Day                            |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 |                                                                      |                                                    |       |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No                                                                                                                                                                                                                                                                                                                                                                                    |  | (If yes give war or dates of service)                                        |                                                                                                     | 16b. SOCIAL SECURITY NO.<br>217-38-4282                                                                                                                     |                                | 17. INFORMANT<br>Edmond<br>Edward G. Young P.O. Box 67 Mickleton N.J.                                    |                                                                                                 |                                                                      | Address<br>08056                                   |       |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute recurrent myocardial infarction.</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><u>Bronchopneumonia.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 |                                                                      |                                                    |       |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 |                                                                      |                                                    |       |                                |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                                                                                     |                                                                                                                                                             |                                | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |                                                                                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                                    |       |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                                                                                                                                                     |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                                                                                                     | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |                                |                                                                                                          |                                                                                                 |                                                                      |                                                    |       |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                               |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                                                                                     | 21f. LOCATION Street or R.F.D. No.                                                                                                                          |                                | City or Town                                                                                             |                                                                                                 | County                                                               |                                                    | State |                                |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>1-27-</u> 19 <u>69</u> , to <u>2-24-</u> 19 <u>69</u> , that (a) (we) lost saw the deceased alive on <u>2-24-</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                              |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 |                                                                      |                                                    |       |                                |  |
| 22b. SIGNATURE<br><u>Christiana Feliciano, M.D.</u> DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 | 22c. DATE SIGNED<br>February 25, 1969                                |                                                    |       |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Christiana Feliciano, M.D.                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                |                                                                                                          |                                                                                                 | 22e. ADDRESS<br>7620 York Road, Towson, Md. 21204                    |                                                    |       |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 23b. DATE<br>2-27-1969                                                       |                                                                                                     | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery                                                                                                  |                                |                                                                                                          | 23d. LOCATION (City or Town)<br>Baltimore                                                       |                                                                      | (County)                                           |       | (State)<br>Md.                 |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Belair Road 21236                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |                                                                                                     |                                                                                                                                                             |                                | 25a. REC'D BY REGISTRAR<br>DATE<br>FEB 28 1969                                                           |                                                                                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |                                                    |       |                                |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02193

02189

|                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Robert</i> <i>First</i> <i>S.</i> <i>Middle</i> <i>Young</i> <i>Lost</i>                                                                                                                                                                                                                                                                                                  |  | 2a. DATE OF DEATH<br><i>Feb.</i> <i>Month</i> <i>18</i> <i>Day</i> <i>69</i> <i>Year</i>                                                                                                                                                                                                                                      |  | 2b. HOUR<br><i>M</i>                                                                                                                                        |  |
| 3. SEX<br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                            |  | 4. RACE<br><i>White</i>                                                                                                                                                                                                                                                                                                       |  | 5. DATE OF BIRTH<br><i>Sept. 26, 1961</i>                                                                                                                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Balto. City</i>                                                                                                                                                                                                                                                                                                                                                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                                                                                                                                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. COUNTY OF DEATH<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                           |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>None</i>                                                                                                                                                                                                                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>                                                                                                            |  |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>                                                                                                                                                                                                                                                                                                                                                                 |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>311 Walgrove Road</i>                                                                                                                                                                                                                      |  | 12c. KIND OF BUSINESS OR INDUSTRY<br><i>None</i>                                                                                                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                      |  | 13b. COUNTY<br><i>Balto.</i>                                                                                                                                                                                                                                                                                                  |  | 13c. CITY OR TOWN<br><i>Reisterstown</i>                                                                                                                    |  |
| 13d. INSIDE CITY LIMITS?<br><i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>                                                                                                                                                                                                                                                                                                               |  | 13e. STREET AND NUMBER<br><i>311 Walgrove Rd.</i>                                                                                                                                                                                                                                                                             |  | 13f. STREET AND NUMBER<br><i>311 Walgrove Rd.</i>                                                                                                           |  |
| 14. FATHER'S NAME <i>Leonard</i> <i>First</i> <i>Young</i> <i>Middle</i> <i>Young</i> <i>Lost</i>                                                                                                                                                                                                                                                                                                                |  | 15. MOTHER'S MAIDEN NAME <i>Harriet</i> <i>First</i> <i>Berman</i> <i>Middle</i> <i>Berman</i> <i>Lost</i>                                                                                                                                                                                                                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><i>No</i> (If yes give war or dates of service)                                                             |  |
| 16b. SOCIAL SECURITY NO.<br><i>None</i>                                                                                                                                                                                                                                                                                                                                                                          |  | 17. INFORMANT<br><i>Mr. Leonard Young</i>                                                                                                                                                                                                                                                                                     |  | Address<br><i>3804 Kilburn Rd. Randall St</i>                                                                                                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br><i>480x</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Virus - Respiratory</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Child - mentally retarded</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>3 days</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>Child - mentally retarded</i>                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                             |  |
| 19a. DATE OF OPERATION<br><i>Feb. 20, 69</i>                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Child - mentally retarded</i>                                                                                                                                                                                                                                          |  | 20a. AUTOPSY?<br><i>YES</i> <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/>                                                          |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>YES</i>                                                                                                                                                                                                                                                                                                                               |  | 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. <i>19</i> Month <i>18</i> Day <i>19</i> Year <i>19</i>                                                                     |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><i>Child - mentally retarded</i>                                                                                                                                                                                                                                                                                              |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><i>Child - mentally retarded</i>                                            |  |
| 21f. LOCATION Street or R.F.D. No. <i>Child - mentally retarded</i>                                                                                                                                                                                                                                                                                                                                              |  | City or Town <i>Child - mentally retarded</i>                                                                                                                                                                                                                                                                                 |  | County <i>Child - mentally retarded</i>                                                                                                                     |  |
| 21g. State <i>Child - mentally retarded</i>                                                                                                                                                                                                                                                                                                                                                                      |  | 22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-69</i> , to <i>2-18-69</i> , that (I) (we) last saw the deceased alive on <i>2-17-69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><i>James G. Saffell MD</i>                                                                                                                |  |
| 22c. DATE SIGNED<br><i>2-19-69</i>                                                                                                                                                                                                                                                                                                                                                                               |  | 22d. PHYSICIAN'S NAME (Type)<br><i>James G. Saffell MD</i>                                                                                                                                                                                                                                                                    |  | 22e. ADDRESS<br><i>Reisterstown, Md</i>                                                                                                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>                                                                                                                                                                                                                                                                                                                                                       |  | 23b. DATE<br><i>Feb. 20, 69</i>                                                                                                                                                                                                                                                                                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Rosewood Cemetery</i>                                                                                              |  |
| 23d. LOCATION (City or Town)<br><i>Awings Mills, Md.</i>                                                                                                                                                                                                                                                                                                                                                         |  | (County)<br><i>Md.</i>                                                                                                                                                                                                                                                                                                        |  | (State)<br><i>Md.</i>                                                                                                                                       |  |
| 24. FUNERAL DIRECTOR<br><i>J. F. Eline &amp; Sons</i>                                                                                                                                                                                                                                                                                                                                                            |  | ADDRESS<br><i>Reisterstown, Md.</i>                                                                                                                                                                                                                                                                                           |  | 25a. REC'D BY REGISTRAR<br><i>FEB 25 1969</i>                                                                                                               |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                             |  |

28180

28180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                       |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|--------------------------|--|
| 1. DECEASED-NAME (Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                 |  | First                                                                        |  | Middle                                                                                                                                                   |  | Last                                                                                         |  | 20. DATE OF DEATH        |  |
| William                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Henry                                                                        |  | Zander, Jr.                                                                                                                                              |  | February 28, 1969                                                                            |  | 2b. HOUR 3:40 p. M.      |  |
| 3. SEX                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 4. RACE                                                                      |  | 5. DATE OF BIRTH                                                                                                                                         |  | 6. AGE (In years birthday)                                                                   |  | IF UNDER 1 YEAR          |  |
| male                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | white                                                                        |  | April 19, 1911                                                                                                                                           |  | 57 YRS.                                                                                      |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7b. CITIZEN OF WHAT COUNTRY?                                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                                                           |  |                          |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | U. S.                                                                        |  |                                                                                                                                                          |  | Baltimore                                                                                    |  | Md.                      |  |
| 1d. CITY OR TOWN OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)                                                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                                            |  |                          |  |
| Catonsville                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | SPRING GROVE STATE HOSP.                                                     |  | printing technician                                                                                                                                      |  |                                                                                              |  |                          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                                                                                                                                                                                                                                                                                                                                    |  | 13b. COUNTY                                                                  |  | 13c. CITY OR TOWN                                                                                                                                        |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| Md.                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | Balto.                                                                       |  | Baltimore                                                                                                                                                |  |                                                                                              |  | 1024 Woodson Rd.         |  |
| 14. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                |  | First                                                                        |  | Middle                                                                                                                                                   |  | Last                                                                                         |  | 15. MOTHER'S MAIDEN NAME |  |
| William H. Zander, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  | Mary                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)                                                                                                                                                                                                                                                                                                                                                                               |  | 16b. SOCIAL SECURITY NO.                                                     |  | 17. INFORMANT                                                                                                                                            |  | Address                                                                                      |  |                          |  |
| No                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 212-07-1116                                                                  |  | Records: SPRING GROVE STATE HOSPITAL                                                                                                                     |  |                                                                                              |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| PART 1. DEATH WAS CAUSED BY:                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| IMMEDIATE CAUSE (a) <i>acute myocardial infarct</i>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF <i>retrograde cardiac conduction</i>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| (b) <i>acute myocardial infarct</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| DUE TO, OR AS A CONSEQUENCE OF <i>acute myocardial infarct</i>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| (c) <i>acute myocardial infarct</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                                                                                                                                                                                                                                                                                                               |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| <i>Infarct - Extensive CVA</i>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                        |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                               |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                          |  |                                                                                              |  |                          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                                                                             |  |                                                                                              |  |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 26, 1967</i> , to <i>Feb. 28, 1969</i> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <i>Feb. 28, 1969</i> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) did not view the body after death. |  |                                                                              |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| 22b. SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 22c. DATE SIGNED                                                             |  | 22d. PHYSICIAN'S NAME (Type)                                                                                                                             |  |                                                                                              |  |                          |  |
| <i>Rafael H. Marin</i>                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 2-28-69                                                                      |  | Rafael H. Marin, M.D.                                                                                                                                    |  |                                                                                              |  |                          |  |
| 22e. ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 22f. ADDRESS                                                                 |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| SPRING GROVE STATE HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Baltimore, Maryland 21228                                                    |  |                                                                                                                                                          |  |                                                                                              |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                                                                                                                                                                                        |  | 23b. DATE                                                                    |  | 23c. NAME OF CEMETERY OR CREMATORY                                                                                                                       |  | 23d. LOCATION (City or Town) (County) (State)                                                |  |                          |  |
| Burial                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 3-3-69                                                                       |  | Moreland                                                                                                                                                 |  | Balto., Md.                                                                                  |  |                          |  |
| 24. FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                             |  | ADDRESS                                                                      |  | 25a. REC'D BY REGISTRAR                                                                                                                                  |  | 25b. REGISTRAR'S SIGNATURE                                                                   |  |                          |  |
| Leonard J. Ruck, Inc., 5305 Harford Rd.                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                              |  | MAR 3 1969                                                                                                                                               |  | <i>Charles Judge</i>                                                                         |  |                          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>7</div> <div>1</div> <div>02195</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02191</div>                                                                                                                                                                                                                                                                                                       |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                             |                                                   |                                                                                             |                                          |                 |                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|-----------------|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | First<br><b>MARY</b>                                                                                      |  | Middle<br><b>D.</b>                                                                                                                                         |  | Last<br><b>ZOELLER</b>                                                                                      |                                                   | 2a. DATE OF DEATH<br>Month <b>02</b> Day <b>03</b> Year <b>69</b>                           |                                          |                 | 2b. HOUR<br><b>3:20</b> M     |  |
| 3. SEX<br><b>F.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4. RACE<br><b>Caucasian</b>                                                                               |  | 5. DATE OF BIRTH<br><b>December 15, 1903</b>                                                                                                                |  |                                                                                                             | 6. AGE (In years last birthday)<br><b>65</b> YRS. |                                                                                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                 | IF UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                           |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.                                                                  |                                                   |                                                                                             |                                          |                 |                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address)<br><b>GREATER BALTO., MED. CEN</b> |  |                                                                                                                                                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Saleslady</b> |                                                   |                                                                                             | 12b. KIND OF BUSINESS OR INDUSTRY        |                 |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 13b. COUNTY<br><b>Baltimore</b>                                                                           |  | 13c. CITY OR TOWN<br><b>Lutherville</b>                                                                                                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |                                                   | 13e. STREET AND NUMBER<br><b>8718 Valley Field Rd.</b>                                      |                                          |                 |                               |  |
| 14. FATHER'S NAME First<br><b>Stephen</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | Middle<br><b>Wohlleb</b>                                                                                  |  | Last<br><b>Nora</b>                                                                                                                                         |  | 15. MOTHER'S MAIDEN NAME First<br><b>Nora</b>                                                               |                                                   | Middle<br><b>McPartland</b>                                                                 |                                          | Last            |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16b. SOCIAL SECURITY NO.<br><b>150-20-9807</b>                                                            |  | 17. INFORMANT<br><b>Mrs. Irene Keesler</b>                                                                                                                  |  |                                                                                                             |                                                   | Address<br><b>Same as # 13 E</b>                                                            |                                          |                 |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE TUBULAR NECROSIS</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>12 YEARS</b> |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                             |                                                   |                                                                                             |                                          |                 |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>NON-FUNCTIONING LEFT KIDNEY AORTIC ANEURYSM</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                             |                                                   |                                                                                             |                                          |                 |                               |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                                          |  |                                                                                                                                                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |                                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |                                          |                 |                               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                                                                                                                                                                                                      |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                                                             |  |                                                                                                             |                                                   |                                                                                             |                                          |                 |                               |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. <b>1/31</b>                                                                                                              |  | City or Town <b>69</b>                                                                                      |                                                   | County <b>2/3</b>                                                                           |                                          | State <b>69</b> |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> , 19 <b>69</b> , to <b>2/3</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>2/3</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                                                                                                                                                        |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                                             |                                                   |                                                                                             |                                          |                 |                               |  |
| 22b. SIGNATURE<br><i>Dr. M. Sheppard</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 22c. DATE SIGNED<br><b>2/3/69</b>                                                                         |  | 22d. PHYSICIAN'S NAME (Type)<br><b>DR. M. SHEPPARD</b>                                                                                                      |  | 22e. ADDRESS<br><b>6701 N. CHARLES ST. BALTO. MD 21204</b>                                                  |                                                   | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                          |                 |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 23b. DATE<br><b>2-6-69</b>                                                                                |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cemetery</b>                                                                                              |  | 23d. LOCATION (City or Town)<br><b>Fairview</b>                                                             |                                                   | (County)<br><b>New Jersey</b>                                                               |                                          | (State)         |                               |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Inc. Towson, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 25a. REC'D BY REGISTRAR<br><b>FEB 4 1969</b>                                                              |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                            |  |                                                                                                             |                                                   |                                                                                             |                                          |                 |                               |  |



MILITARY .6

## REFERENCES

English

de J. M. C.

70-60897-100-235

1900

5-6-68

Y. K. Kozlov

1050 2701 0501

Dr. Cook-Brooks, Lewiston, Me., Lewiston, Me.